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FACTORS AFFECTING THE COMMUNITY READJUSTMENT OF MENTAL HOSPITAL PATIENTS

A Statistical Analysis From the Viewpoint of Social Service and Readjustment of 148 Patients With Mental Disorder Who Left Worcester State Hospital in 1938

A Thesis

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Submitted by

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(A.B., Brown University, 1940)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1942

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I - PURPOSE

During the early years of this century psychiatric social work was just in its embryonic stages, but in the few decades since then the service has made phenomenal gains. Throughout this period, like many other growing organizations, it has been on the defensive. Much of the psychiatric social workers' efforts were devoted toward "proving" that their functions were vital to patients leaving mental hospitals.

Studies were made to show that the numbers of patients released from mental hospitals increased appreciably with the advent of social service. Statistics were computed to indicate that the savings resulting from patients staying out on visit were greater than the cost of maintaining the social work supervision.[1] Case after case was carefully selected to indicate "how" the social worker had been

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[1] American Association of Psychiatric Social Workers, Psychiatric Social Work and the State Hospitals (April 1928), p. 5.

indispensable in the readjustment of a particular patient upon return to the community.

Today such concern about proving the worth of social work in a psychiatric hospital is no longer warranted. Psychiatric social workers now have their own organization and are employed in over 400 agencies.[2] The American Psychiatric Association not only recognizes the importance of social service for mental patients, but has even outlined how the psychiatrist and case worker can combine their efforts.[3] That the social "aspect of therapy is just as essential as physical treatment or any other component of the reconstructive process"[4] is becoming an accepted point of view.

Now that social service is established within mental hospitals, case workers would do well to spend more time in analyzing their methods and techniques. At present the scope and limits of the service are poorly defined.

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[2] Lois M. French, Psychiatric Social Work (New York: The Commonwealth Fund, 1940), p. 80.

[3] American Psychiatric Association, Report of Committee on Psychiatric Social Service, American Journal of Psychiatry, 13 (90 old series): 434, September, 1933.

[4] Frank E. Howard and Frederick L. Patry, Mental Health (New York: Harper, 1935), p. 329.

The relationship of social work departments to the other services of the hospital has not been as yet completely worked out. The question of what and where social services are most effective is far from adequately answered. Undoubtedly the overly rapid growth of psychiatric social work and the rapid turnover of the personnel within the field had prevented the consistent and prolonged study which these problems require. Yet such study is essential if psychiatric social work is to continue developing.

Thus this thesis is written not to prove the "success" of social work in a mental hospital, for this, or the opposite, can only be measured if one could tell what would happen if case work aid was not given to a particular patient. Rather, it is an endeavor to learn what are the characteristics of mental patients who are followed by case workers as compared with those patients who leave the hospital without receiving the service; and also, to discover what types of patients better readjust to the community. After determining these factors another question arises, namely, could certain steps have been taken which might have insured a more satisfactory readjustment of the patient to the community? This is the basic objective of the study.

II - DELIMITATION

Both the intensive case study method and the statistical lend themselves to answering the problem of this thesis -- what patients receive social service as compared with those who don't, and what are the differences in readjustments? Although the former method would perhaps present a more detailed analysis, it could not be applied to a large group of patients within a comparatively short time. Since as representative a study as possible was desired, the statistical method was utilized.

The cases selected for study had all been patients at the Worcester State Hospital. Since this mental hospital is an observation, as well as treatment center, many patients who are admitted do not have a mental disorder and are therefore discharged at the end of their observation period. These were excluded from the selection as the objective of this thesis is to learn about patients with mental disorders who return to the community after hospitalization. Such patients return to the community in one of three ways. Either they are discharged "on

visit", or go "ORAA", or are placed in family care.

The Massachusetts Department of Mental Health defines the term discharge "on visit" as

> ...a discharge to relatives or friends who agree to assume financial support and care with the understanding that if the patient remains outside the Hospital for one year, the visit becomes an absolute discharge. During the year the patient may be returned at any time to the Hospital without commitment. Renewal of the "on visit" status of a patient requires that before the year has expired the patient must return to the Hospital for overnight stay and examination. This must be repeated once a year while the patient is considered "on visit". In this way the relatives are able to keep the patient in their home and if the patient is mentally disturbed, he may be returned to the Hospital without a new Court commitment.[1]

Such a discharge is made by the staff only when it is felt that a patient has sufficiently recovered from his mental condition to return to the community and that the plans for his care and supervision in the community are not likely to reactivate his mental disorder.

The abbreviation "ORAA" stands for "on request against advice", i.e., the patient was released on request of the relatives or guardian even though the psychiatric staff did not think it advisable. In such instances the patient is likewise discharged "on visit".

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[1] Department of Public Welfare, Manual of Laws, Rules, Policies, and Procedures for the Administration of Public Assistance (Sept. 1939; Revised May 1941) ch. VI, p. 7A - 8.

The reasons for placing a patient in a hospital-supervised family care home are more varied. In some cases there is no one who can or will assume the responsibility for the patient. Yet the doctors may feel that he does not need further hospitalization. Since the patient may not be sufficiently recovered to be released in his own care, the staff may resort to family care. In other instances, the patient may not have gotten along well when out on previous visits with relatives or friends and the family care home is tried to see if there are any changes in the patient's readjustment. Largely because of these reasons, family-care placements have gained a reputation for being very likely to return to the hospital within a short time. But in others the doctors recommend family care as a form of treatment, or, while further plans are being considered, as a temporary placement to learn how the patient will get along when not subject to the hospital routine. Family care patients are not discharged "on visit" status. If their adjustment is satisfactory, the patients may be placed "on visit" by the staff and thereafter discharged after a year under the same conditions as the previous categories.

Although these three means -- discharge "on visit", "ORAA", and family care -- by which patients with mental

disorder leave the hospital differ widely in some respects, they are all included in the study as they have a common purpose. That purpose -- to return the patient to the community -- is the aim of the mental hospital. Moreover, the analysis of patients going on these trial visits into the community and how they adjust is the question of this paper.

The next problem was the classification of patients according to social services. Family care which is under the supervision of the social work department, needs no further defining. If a patient's record showed that the department performed any service in relation to planning for the patient's return to the community, that case was labeled "social service". These cases were further subdivided for this study into "intensive cases" and "visit resources". Under the former heading were included those patients regarding whom social workers had no less than five contacts which extended at least for a month after the patient's discharge "on visit". Those patients which required fewer contacts over a shorter period were included in the "visit resource" category. All the others were listed as "non-service", and formed a control group with which the "social service" patients were compared.

After the determination of which patients would be

sampled and how they would be classified, the next consideration was the definition of "readjustment". Here many criteria suggested themselves -- the absence of symptoms of psychosis, the opinion of relatives, the degree to which a patient had resumed the role he had prior to admission. Many such definitions were questioned because of their subjectivity. Others were impractical, because follow-up visits and interviews of patients and relatives on an extensive basis were impossible. Still others had to be discarded because of inadequate record material. Finally a single criterion was decided upon: readmission.

The reason for selecting readmission as the basis for adjustment lies in the factors which led to the patient's original hospitalization. Because of bizarre behavior or inability to get along with others, the patient is first committed to a mental hospital for observation, but only on complaint of the community -- relatives, neighbors, doctor, police, court. If diagnosed as mentally ill, hospitalization and treatment are prescribed by the hospital staff. Sooner or later, in many cases a trial visit in the community is recommended.

> We do not disparage any mental institution that returns a patient to the community when there remain some traces of psychoses or other mental disorder within that patient. The hospital alone cannot make or hope

> to make every person who has been under its care ready for a renewal of those activities which had been the patient's life before commitment...Because of the number of patients in a hospital, the staff, adequate though it may be, cannot achieve individual treatment on a scale that is ideal no matter how much such a plan is desired...In the first place, it is economically impossible, and too, such a staff would be difficult to organize.
>
> What a reputable hospital...can and does do is carry out a manifold treatment. Psychiatrists and medical practitioners with their assistants in this field render specific services to keep the patient physically sound and alleviate the mental diseases in so far as possible...Another phase of treatment is through work and social activities...
>
> In spite of this, however, the hospital alone cannot accomplish the complete operation of sending the patient back to the community ready to take up his usual mode of living. It remains for the community to assume a share of responsibility...
>
> The hospital does appreciate the seriousness of the responsibility that the community has, so that...the patients are released under the plan of "visit discharge".[2]

Thus the community is again the final judge. It decides whether the released patient is "cured" or not. That, in some instances, patients may be sheltered and tolerated in the community even though their mental disturbances are still present must be admitted. This is

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[2] Francis J. Murphy, "A Study of the Work Adjustment of 100 Selected Patients on Discharge Visit from the Worcester State Hospital," Unpublished Master's Thesis, Boston University, Boston, 1941, p. 9-11.

also true of many who have never been hospitalized. As no new court commitment is necessary to have patients discharged "on visit" rehospitalized, the ease with which these patients can be readmitted alone seems to disprove this argument. In fact patients are often returned for but minor reasons. Of course, the patient is again returned to the community if the staff decides the patient's mental condition does not warrant hospitalization. At any rate, it is likely that a community having once committed a person who did not adjust satisfactorily would do so again if the patient continues to be maladjusted. Non-readmission is therefore considered the single criterion of readjustment.

When patients need rehospitalization they are almost invariably returned to the mental hospital in which they were previously treated. In cases where this is not done, the practice is for the psychiatrist to write for an abstract of the patient's record at the former hospital. In such instances the request would be filed in the record. A careful check was made for such correspondence.

This factor of readjustment was the primary consideration in the selection of the year from which the sample of patients was to be taken. An attempt was made to set the date as far back as possible, the assumption being that

the longer the patient remained in the community, the less the probability that serious maladjustment or presence of overt psychotic symptoms would be tolerated. However, since the records before 1938 were not in usable condition, that year was chosen.

A random sample of an equal number of social service cases and non-social service cases was impossible to obtain as there was no way of distinguishing the two except by reading the actual records. Thus a sample was taken by months. In order to avoid possible seasonal bias, the second, fifth, eighth and eleventh months were used. All the cases discharged "on visit" or to family care during these months were secured from the day books on the male and female psychiatric services. The former appeared to have been inconsistently and haphazardly kept, therefore the male sample may not be complete.

The schedule (Appendix A) used in gathering the material from the records was delimited to include facts relating to following: nativity, education, economic status, marital status, hospitalization, diagnosis, age on release, visit resources, and employment. The distribution of subdivisions within each of these and the degrees of their readjustment were computed according to sex and social service. The selection of these nine factors was determined by availability and adequacy of record material.

III - SAMPLING

The conclusions of any statistical study rest primarily upon the sample selected for analysis. In the instance of this thesis, the reliability of the sample can not be adequately determined, except perhaps in the case of patients who were placed in family care. The department of mental health yearly reports do not tabulate statistics for patients discharged "on visit".[1] Patients are classified rather on basis of all visit placements or of number discharged without further hospital supervision. The former group includes patients who went on short visits, as well as those who were released on a year's trial period. The "discharged" classification[2] excludes patients who were released for the probation period of a year, but had to be rehospitalized. Furthermore, no social service statistics are given in these annual reports.

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[1] Commonwealth of Massachusetts, Department of Mental Health, Report of the Commissioner (November, 1938), p. 139.

[2] Ibid., p. 190.

Consequently the reliability of the sample used must rest on the method of selecting the patients. As explained in the previous chapter, all the patients with mental disorder listed as discharged "on visit" or going into family care homes during the median months of each season were included. Thus subjective choice and possible seasonal variation were eliminated. In determining which cases were to be considered "social service" the criteria were likewise objective. Therefore the representativeness of the sample depends also on how well the hospital records were maintained in the year 1938. It has already been mentioned that the day book on the male service was not as clear and orderly as the day book of female patients. Also there were indications in several of the patients' records that social service contacts had not been inserted. These factors undoubtedly influenced the results obtained, but the probable error is undeterminable.

DISTRIBUTION - Using the criteria outlined, the sample totaled 148 patients of both sexes (Table 1). Sixty-one or 41.2% were males; and 87 or 58.8% were females. The total number returning to the community during the four months sampled was fairly constant, ranging only from 33 to 43. The female monthly totals showed less variation than the males. The former ranged from 20 to 24, while the

male spread was from 12 to 23 per month. This may be explained partially by difference in the orderliness and clarity of the day books on the female and male wards at that time.

In comparison, 718 patients had been placed on visit during the year ending November 30, 1938.[3] Of this total 348 were males and 370 females. In the same period 443 patients -- 269 males and 174 females -- were discharged.[4] Although it is admitted that these figures are not homogeneous with those of the sample, some indications may be secured as to the reliability of the sample from a comparison of the two. Since the totals for patients placed on visit include more than the sample, and the discharge statistics less, the twelve month total of patients returning to the community for a year's trial period should be between the former totals. When one multiplies the four month sample by three, the result is 484 patients. Even though this figure is between 718 and 443, the indication is that it may be low. Perhaps the male sample was inadequate. This cannot be determined as the proportion of males placed on visit in the annual report was smaller than that of females; while the opposite occured

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[3] *Ibid.*, p. 139.
[4] *Ibid.*, p. 190.

among the patients discharged.

Six-tenths of the patients returning to the community were given social service in 1938 (Table 2). Nearly half of the males were classified under this service; but of the females there were two-thirds. Although the slightly higher percentage of intensive male cases does not completely account for this difference, it was observed that these included a greater number of interviews over a longer period of time than the female intensive cases.

The sharpest contrast within the types of social service is between male and female where the service was limited to visit resource. Three times the proportion of males were given visit resource service among the females: nine and eight-tenths percent to 29.9%. If this difference is absolute, then one is confronted by the question of why do males, as contrasted with females, require more intensive case service and less visit resource? In this study no explanation of the question was even suggested.

The percent of males and females placed in family care homes were virtually equal -- 18.1% and 19.5% respectively. Since the admissions to family care during 1938 are included in the mental health statistics,[5] the representativeness of the sample in this category alone

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[5] *Ibid.*, p. 141.

Table 1: Sample of Patients with Mental Disorder Returned to the Community from Worcester State Hospital in 1938 by Sex and Months.

Month	Male	Female	Total
February	13	20	33
May	23	20	43
August	13	24	37
November	12	23	35
Total	61	87	148

Table 2: Patients According to Type of Service Received When Returning to the Community by Sex.

Service	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Intensive Case	13	21.3	16	18.4	29	19.6
Family Care	11	18.1	17	19.5	28	18.9
Visit Resource	6	9.8	26	29.9	32	21.6
Social Service	30	49.2	59	67.8	89	60.1
Non-Service	31	50.8	28	32.2	59	39.9
Total	61	100.0	87	100.0	148	100.0

can be adequately determined. In the entire year 83 patients were placed in family care. The sample sum of 28 is almost exactly one third of the year total, which seems to show that the sampling was numerically representative. However, while the annual statistics on number of males and females - 40 and 42 - are nearly equal, in the sample there were 11 males and 17 females who went to family care homes. This supports the suspicion that the male sample is not truly adequate.

Summary: All the patients returning to the community from the mental hospital during the median months of each season of 1938 were selected for study. The representativeness of the sample, however, could not be determined for lack of homogeneous statistics. Sixty percent of the sample of 148 patients were female. Two-thirds of them received social service as compared with only half of the males. A greater portion of the males were intensive cases; while more of the females were classified as visit resource. The proportion of family care among male and female patients were about equal.

READJUSTMENT - Fifty-four percent or 80 out of the 148 patients remained in the community for three full years after their release from the mental hospital in 1938 (Table 3). The female patients showed a higher rate of

readjustment to community life than the males -- 57.5% to 49.2%. In each sex, patients aided by social service readjusted only slightly better than those in the non-service grouping. The readjustment rate for social service, both sexes included, was 55.1% and for non-service, 52.5%.

The highest rate of adjustment by types of social service was visit resource, 66.7%, for the males, and family care, 64.7%, for the females. Each is based on only a small number of patients and cannot therefore be considered conclusive. Intensive cases of the male social service had a rate of 61.5% readjusted as compared with 56.3% of the females receiving the same type of service. Males going into family care showed poorest readjustment rates, but the sample only included seven patients. Nevertheless, this is in contrast to the high percent of females remaining in the community after being placed in family care homes. The lowest rate for females, 53.8%, was for patients classed as visit resource. Female patients showed a more uniform rate of readjustment, regardless of type of service, than the males. This was true also of non-social service cases.

When the average lengths of visit for social service and non-service patients are compared (Table 4), the differences are less than a month. The female non-service

patients stayed out slightly longer than the social service. The converse was true among the males. Male family care was the only group which did not come within three months of the grand average of 22.1 months. It had an average of only 13.1 months. The next lowest group was male non-service with a 19.6 month average. The female patients stayed out 3.6 months longer than the males, who averaged 20 months.

Of the 68 patients who were rehospitalized, 55 were readmitted within one year after their release on trial visit. Moreover, 40 returned within six months; 30 were back in the hospital within three months. This evidence substantiates the policy of allowing the patient to remain for a year in the community before discharging him from hospital supervision.

Of course many of the patients who returned to the hospital went out on visits again. In fact at the end of the three year period only 33 patients or 22.3% were in a mental hospital. All of these but two were at the Worcester State Hospital. The percent of males as opposed to females in this group was 24.6% to 20.7%. Since some patients who first went out as non-service received social service when going on their second visit, and vice versa, no comparisons between first and second visits were made.

It may be added that only seven patients were discharged on visit by request of relatives or friends against the advice of the staff. Four were male patients and three female. Three of the seven remained in the community for the full three years.

Summary: A little over half of the 148 patients were not readmitted during the three year period covered by the study. Female patients readjusted better than male. Social service showed only slightly higher percentage of readjustment than non-service. Male intensive cases had the highest significant rate of adjustment under social service; while family care had the highest on the female service. Female patients averaged slightly longer visits than males. The difference in length of visit between social service and non-service was not significant. Male family care showed an extremely short visit average in comparison with the other forms of service. A majority of the patients who were rehospitalized were admitted within one year after release. Only one-fifth of the original sample was in a mental hospital at the end of the three year period. Just seven cases left the hospital ORAA.

Table 3: Number and Percent of Patients Readjusted in Each Type of Service.

Service	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Intensive Case	8	61.5	9	56.3	17	58.6
Family Care	3	27.3	11	64.7	14	50.0
Visit Resource	4	66.7	14	53.8	18	56.3
Social Service	15	50.0	34	57.7	49	55.1
Non-Service	15	48.5	16	57.2	31	52.5
Total	30	49.2	50	57.5	80	54.0

Table 4: Average Length of Visit in the Community by Type of Social Service and Sex.

Service	Male	Female	Total
		(Number of Months)	
Intensive Case	24.9	23.6	24.2
Family Care	13.1	23.5	19.4
Visit Resource	24.7	23.1	23.4
Social Service	20.5	23.4	22.4
Non-Service	19.6	24.2	21.7
Average	20.0	23.6	22.1

IV - NATIVITY

The influence of culture on individuals is being more recognized currently as a result of the studies of sociologists, social psychologists, and social psychiatrists. Particularly attention is focused upon cultural conflicts within family groups. Analyses of delinquency rates have shown a higher ratio among native born children of foreign parentage than for any other nativity group. Is cultural conflict also an important factor in the dynamics of mental illness? Evidence seems to support this. On a basis of corresponding population,

> ...the foreign born present the highest admission rate and the native born of foreign parentage reveal somewhat lower rates. The native born of mixed parentage are still lower in rates and the native born of native parentage present the lowest level of rates.[1]

The purpose of studying patients leaving a mental hospital according to nativity was to discover if there was also a differential in the distribution and readjustment of the various groups.

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[1] Neil A. Dayton, New Facts on Mental Disorder (Springfield: Charles C. Thomas, 1940), p. 81.

DISTRIBUTION - As might be expected, the native born of native parentage formed the largest nativity group with 47 patients or 31.7% of the total sample (Table 5). The next highest was the native born with foreign parentage, totalling 35 or 23.6%. The foreign born with foreign parentage were in third place with 20.9%, or 31 patients. The other groups were less than ten percent each, falling in the following order: native born of mixed parentage, 9.5%; Canadian born of Canadian parentage, 6.8%; and native born of Canadian parentage 4.1%.

Among the female patients the order of distribution was exactly the same. The native born of native parentage were even more dominant in this sex, for they formed 36.8% of the total. Next came native born of foreign parentage, 18.4%, and foreign born with foreign parentage, 17.3%.

The males, however, had a majority of native born of foreign parentage. These patients were 31.2% of the male total. The next largest group was the foreign born of foreign parentage, 26.2%. The native born males of native parentage, unlike the females, ranked third with 24.6%. Patients with native parentage thus predominated among the females, and with foreign parentage among the males.

This apportionment was considerably different when only male social service patients were enumerated (Table 6).

The foreign born group comprised the largest portion of the male social service, and third largest of the non-service. The percentages were 45.3% and 9.7% respectively. The native born males of foreign parentage with 23.3% formed the next largest group under the social service classification. This group, adding to 38.7%, was the largest under non-service. The third largest social service nativity group on the male side was the native born of native parentage. It was 16.7%, while under non-service it was second largest with 32.3%.

There was less percentage variation between female social service and non-service patients (Table 7). The differences were less than five percent within each of the three largest nativity groups. In both the social service and non-service categories the native born of native parentage were the largest groups -- 37.3% and 35.3%. This is in contrast to what was found among the males. Under female social service the second and third groups were foreign born, 18.6%, and native born of foreign parentage, 17%. These nativity groups were in reverse order under non-service. The foreign born were 14.3% and the latter, 21.4% of the total.

Following these computations, the portion of each nativity group followed by social service was determined

Table 5: Nativity Groups and Sex.

Nativity	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Native Born of Native Parentage	15	24.6	32	36.8	47	31.7
Native Born of Mixed Parentage	4	6.6	10	11.5	14	9.5
Native Born of Foreign Parentage	19	31.2	16	18.4	35	23.6
Foreign Born of Foreign Parentage	16	26.2	15	17.3	31	20.9
Native Born of Canadian Parentage	3	4.9	3	3.4	6	4.1
Canadian Born of Canadian Parentage	2	3.3	8	9.2	10	6.8
Unknown Nativity or Parentage	2	3.3	3	3.4	5	3.4
Total	61	100.1	87	100.0	148	100.0

Table 6: Nativity of Social Service and Non-Service Male Patients.

Nativity	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Native Born of Native Parentage	5	16.7	10	32.3	15	24.6
Native Born of Mixed Parentage	2	6.7	2	6.4	4	6.6
Native Born of Foreign Parentage	7	23.3	12	38.7	19	31.2
Foreign Born of Foreign Parentage	13	43.3	3	9.7	16	26.2
Native Born of Canadian Parentage			3	9.7	3	4.9
Candaian Born of Canadian Parentage	2	6.7			2	3.3
Unknown Nativity or Parentage	1	3.3	1	3.2	2	3.3
Total	30	100.0	31	100.0	61	100.1

Table 7: Nativity of Social Service and Non-Service Female Patients.

Nativity	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Native Born of Native Parentage	22	37.8	10	35.8	32	36.8
Native Born of Mixed Parentage	8	13.5	2	7.1	10	11.5
Native Born of Foreign Parentage	10	17.0	6	21.4	16	18.4
Foreign Born of Foreign Parentage	11	18.6	4	14.3	15	17.3
Native Born of Canadian Parentage	1	1.7	2	7.1	3	3.4
Canadian Born of Canadian Parentage	6	10.2	2	7.1	8	9.2
Unknown Nativity or Parentage	1	1.7	2	7.1	3	3.4
Total	59	100.0	28	99.9	87	100.0

Table 8: Percent of Each Nativity Group Aided by Social Service.

Nativity	Male	Female	Total
Native Born of Native Parentage	33.3	68.7	57.4
Native Born of Mixed Parentage	50.0	80.0	71.4
Native Born of Foreign Parentage	36.8	62.5	48.6
Foreign Born of Foreign Parentage	81.2	73.4	77.4
Native Born of Canadian Parentage	.0	33.3	16.7
Canadian Born of Canadian Parentage	100.0	75.0	80.0
Unknown Nativity or Parentage	50.0	33.3	40.0
Average	49.2	67.8	60.1

(Table 8). Of the males, both of the Canadians received social service, giving this group the highest, but not significant, percentage. Eighty-one percent of the foreign born males, and half of the native born with mixed parentage received social service as either intensive cases, family care or visit resource. The other nativity groups had less than 49.2% social service, which was the average for the males.

In the opposite sex the leading nativity group was native born of mixed parentage, eight out of ten receiving social service. The others above the female average of 67.8% were: Canadian born, 75%; foreign born, 73.4%; and native born of native parents, 68.7%. In contrast the males of the last group only received social service in one out of three cases.

Since the division of nativity groups into the three type of social service would have subdivided the frequencies into very small, and consequently numerically insignificant, portions such a comparison was not attempted.

Summary: The three highest nativity groups among the female patients sampled were, respectively; native born of native parentage; native born of foreign parentage; and foreign born. The native born of foreign parentage were the largest nativity group, however, among the males.

This was followed by the foreign born and native born of native parentage. The distribution among social service patients was: native born of native parentage, foreign born; and native born of foreign parentage. Of the male social service patients the foreign born was the largest group. More than half of the males who were foreign born or native born of mixed parentage received social service. Two-thirds or more of the following female nativity groups were classified social service: native born of mixed parentage; Canadian born; foreign born; and native born of native parentage.

READJUSTMENT - Of all the nativity groups, both sexes included, the native born of foreign parentage adjusted best. Sixty percent of these patients were able to remain in the community for three years without rehospitalization (Table 9). The rate of 58.1% for the foreign born was second. The only other group above the 54% average rate of readjustment for the total sample was that of the native born.

On the other hand the native born males of native parentage had the highest significant rate of readjustment. Six out of every ten of these did not return to a mental hospital. Foreign born males, with a rate of 56.2%, were the only other group above the 49.2% average readjustment

for the sex.

The female nativity groups showed a still different distribution in the rates of readjustment. Heading the list were the native born with foreign parentage with three-fourths readjusting. The native born of Canadian parentage showed a rate of 66.7% on basis of only three cases. The next rate was 60% for the foreign born females.

The lowest rates that can be considered fairly representative were 47.3% for the native born males of foreign parentage and 50% for native born females with mixed parentage. Still, when compared with the above facts, these do not confirm the hypothesis that patients with a cultural background which differs from that of their social milieu are apt to find most difficulty in adjusting. Perhaps rehospitalization is not an appropriate criterion to apply to this problem. Whether or not these foreign parents were more likely to shelter a patient than native parents is an unanswered question.

Separation of the social service from non-service revealed that the native born of foreign parentage of both sexes had the highest rates of readjustment. These were 57.2% for the male social service and 80% for the female social service (Tables 10, 11). Of the patients who did not receive social service, the males native born with native parentage (70%) and the females of foreign birth

(75%) showed greatest incidence of readjustments.

These opposing results prohibit any conclusion regarding the importance of cultural conflict in the readjustment of patients with foreign background. Evidently other factors are equally significant. Are these social factors which are within the sphere of social work?

Summary: The native born of foreign parentage had the highest rate of readjustment, both sexes included. The native born males of native parentage and foreign born males were the two nativity groups above the average rate of readjustment for that sex. The nativity groups readjusting better than the average rate for the female sex were: native born of foreign parentage and foreign born. The lowest significant rates were for native born males of foreign parentage and native born females of mixed parentages. The smallest percentage of readmissions for social service of both sexes was in the native born of foreign parents group; and in foreign born nativity class for the female non-service, and native born of native parents for the male non-service.

These readjustment rates of mental hospital patients do not consistently support the theory that foreign birth or foreign parentage increases difficulties in community

readjustment. Could it be that hospitalization served as an Americanizing or orienting force? Or did other social and personal factors minimize the potential cultural conflicts?

Table 9: Number and Percent of Patients Readjusted in Each Nativity Group by Sex.

Nativity	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Native Born of Native Parentage	9	60.0	17	53.1	26	55.2
Native Born of Mixed Parentage	0	.0	5	50.0	5	35.7
Native Born of Foreign Parentage	9	47.3	12	75.0	21	60.0
Foreign Born of Foreign Parentage	9	56.2	9	60.0	18	58.1
Native Born of Canadian Parentage	1	33.3	2	66.7	3	50.0
Canadian Born of Canadian Parentage	2	100.0	2	25.0	4	40.0
Unknown Nativity or Parentage	0	.0	3	100.0	3	60.0
Average	30	49.2	50	57.5	80	54.0

Table 10: Number and Percent of Male Patients Readjusted in Each Nativity Group by Service.

Nativity	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Native Born of Native Parentage	2	40.0	7	70.0	9	60.0
Native Born of Mixed Parentage	0	.0	0	.0	0	.0
Native Born of Foreign Parentage	4	57.2	5	41.7	9	47.3
Foreign Born of Foreign Parentage	7	53.8	2	66.7	9	56.2
Native Born of Canadian Parentage			1	33.3	1	33.3
Canadian Born of Canadian Parentage	2	100.0			2	100.0
Unknown Nativity or Parentage	0	.0	0	.0	0	.0
Average	15	50.0	15	48.5	30	49.2

Table 11: Number and Percent of Female Patients Readjusted in Each Nativity Group by Service.

Nativity	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Native Born of Native Parentage	13	59.0	4	40.0	17	53.1
Native Born of Mixed Parentage	5	62.5	0	.0	5	50.0
Native Born of Foreign Parentage	8	80.0	4	66.7	12	75.0
Foreign Born of Foreign Parentage	6	54.5	3	75.0	9	60.0
Native Born of Canadian Parentage	0	.0	2	100.0	2	66.7
Canadian Born of Canadian Parentage	1	16.7	1	50.0	2	25.0
Unknown Nativity or Parentage	1	100.0	2	100.0	3	100.0
Average	34	57.7	16	57.2	50	57.5

V - EDUCATION

> As intelligence rises the percentage of personality and emotions problems(..e.g. temper displays, negativism, quarrelsomeness, stubbornness, etc.) increases; as intelligence diminishes, conduct problems or resistance against organized authority increases.[1]

This correlation indicates the importance of intelligence in the personality and social adjustment of the individual. The question that arises in relation to patients with mental disorder, namely, what is the significance of intelligence in readjustment to the community, to society upon leaving the psychiatric hospital?

Although a majority of the patients sampled were tested by the hospital psychologist, the intelligence quotients in but less than half of them were considered optimal. For this reason the highest grade completed in school was used here in place of the I.Q. It is recognized that the two

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[1] John Levy, "A Quantitative Study of Relationship between Intelligence and Economic Status as Factors in the Etiology of Children's Behavior Problems," American Journal of Orthopsychiatry, (June, 1931), p. 55.

are not synonymous, yet the substitution seems justified for two reasons. First many intelligence tests are standardized on the basis of school grades. And secondly, education is increasingly important economically and culturally. Occupations are requiring a rising minimum of schooling. The age to which children are required to attend school has been slowly increased by legislation. Degrees and diplomas are considered a mark of cultural distinction.

DISTRIBUTION - When listed according to the highest schooling completed (Table 12), the total sample of patients returning to the community shows a fairly normal curve of distribution. Subdividing the patients according to sex yields surprisingly different results. Although the modal group was that including the grammar school graduates among the males and females, the latter included 22 who had finished high school, while only two males reached the same level.

The ranges for both sexes were equal, starting with no formal schooling and ending with college degrees. The frequency at these extremes being so few it is not worth making any comparisons. The average grade for all patients was 8.2; while the median was 8.6. The averages for the sexes were: male, 7.5; female, 8.6. The medians were slightly higher in each case: male, 8.4; female, 8.8.

In order to make the true differences in education between the two sexes more evident percentages of the total within each school level were computed (Table 12). Almost equal portions of each sex graduated from the eighth grade and went no further. The males had a slightly larger portion, 41% as compared with the females' 39.1%. The most significant differences appeared in the class intervals of 1-7 grades and of high school graduates. In the group that did not graduate even from grammar school, the males amounted to 24.6% of the sum while among the females only 11.5% were in the same group. The opposite was true in the other interval, for while one out of every four female patients graduated from high school, only 3.3% of the males attained a secondary school diploma. All this evidence indicates that the female patients who returned to the community from the mental hospital in 1938 had more education than the males.

When social service and non-service patients of both sexes were compared, the major difference was in the interval including the grammar school graduates (Tables 13, 14). Among the male patients there was practically an equal proportion in the social service and non-service categories -- 40% and 42% respectively. However, while 47.5% of the females receiving social service went through, but not beyond the eighth grade, only 21.4% of the non-

service female patients did likewise. Since few males went into high school or college, the proportion of them within the social service and non-service male groups were not as large as among the females. In both cases, though, -- male 13.3% to 32.2%; female 27.1% to 64.3% -- the percentages were higher within the non-service classification. Under the eighth grade level the reverse is disclosed. Here the males show a larger difference. Forty percent of the males in the social service group and 19.3% of the non-service patients did not go through the eighth grade as compared with 18.6% of the female social service patients and 14.3% of the non-service of that sex. In both sexes the percentages are larger among social service than among non-service patients below the eighth grade.

When these facts are analyzed further, the results on the basis of the total number of patients showed that the higher the school grade the smaller the proportion of patients followed by social service (Table 15). While 75% of those who had no formal education were more helped by social service with their plans to leave the hospital, only 40% of those going further than secondary schools received this aid.

When each sex was compared,this indirect ratio did not hold completely. The exception among the males in the

twelfth grade group can be explained by the fact that there were only two included in this class. Also contrary to the indirect ratio, the highest proportion of females receiving social service was 82.4% of the patients completing the eighth grade. Of the males within the same school group but 48% were classified as social service patients. The reason for this did not become apparent in this study. Neither can the fact that the low extreme in the female group was 40.8% for the high school graduates be explained. Perhaps the 60% for the female patients having more than high school education is too high as it is based on an inadequate sampling. These figures as a whole corroborate the previous evidence showing that social service is given predominantly to patients with low or no education.

In the comparison of the education levels within the three types of social service, the statistics showed that a larger portion (37.9%) of the intensive cases than of family care (17.8%) or visit resource (21.8%) did not have a grammar school diploma. Although the modal class was the eighth grade, the proportions differed widely among the services -- 57.2% of family care; 43.8% of visit resource; and 34.5% of intensive cases. The percent of patients with secondary education or better was lower in the intensive case (24.1%) and family care (14.3%) categories than in the visit resource (28.1%), but the last did not include

Table 12: Education and Sex.

School Grade Completed	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 12	5	8.2	5	5.8	10	6.8
12	2	3.3	22	25.3	24	16.2
9 - 11	7	11.4	7	8.0	14	9.5
8	25	41.0	34	39.1	59	39.8
1 - 7	15	24.6	10	11.5	25	16.9
None	3	4.9	5	5.7	8	5.4
Unknown	4	6.6	4	4.6	8	5.4
Total	61	100.0	87	100.0	148	100.0

Table 13: Education of Social Service and Non-Service Male Patients.

School Grade Completed	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 12	1	3.3	4	12.9	5	8.2
12	1	3.3	1	3.2	2	3.3
9 - 11	2	6.7	5	16.1	7	11.4
8	12	40.0	13	42.0	25	41.0
1 - 7	10	33.3	5	16.1	15	24.6
None	2	6.7	1	3.2	3	4.9
Unknown	2	6.7	2	6.5	4	6.6
Total	30	100.0	31	100.0	61	100.0

Table 14: Education of Social Service and Non-Service Female Patients.

School Grade Completed	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 12	3	5.1	2	7.1	5	5.8
12	9	15.2	13	46.5	22	25.3
9 - 11	4	6.8	3	10.7	7	8.0
8	28	47.5	6	21.4	34	39.1
1 - 7	7	11.8	3	10.7	10	11.5
None	4	6.8	1	3.6	5	5.8
Unknown	4	6.8			4	4.6
Total	59	100.0	28	100.0	87	100.1

Table 15: Percent of Each School Grade Group Aided by Social Service.

School Grade Completed	Male	Female	Total
Over 12	20.0	60.0	40.0
12	50.0	40.8	41.6
9 - 11	28.6	57.1	42.8
8	48.0	82.4	67.7
1 - 7	66.7	70.0	68.1
None	66.7	80.0	75.0
Unknown	50.0	100.0	75.0
Average	49.2	67.8	60.1

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[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
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any patients with more than 12 years of schooling.

As the samples are small when subdivided by sex and type of social service, no conclusions were drawn from them. The sum results, however, seemed to indicate that more of the intensive cases than of the other two services were in the under-eighth-grade school level.

Summary: Of the patients with mental disorder who returned to the community in 1938, the females had completed more schooling than the males, three-fourths of whom did not go beyond grammar school. The higher the school grade the smaller was the proportion followed by social service. The percent of patients having less than grammar school education was greater among the intensive cases than among family care or visit resource classifications.

READJUSTMENT - The highest readjustment rate among the males - 100% for the high school graduates - must be discounted as there were only two within this class interval (Table 16). The next highest rate for the male patients was based on the more adequate number of fifteen. This was 53.3% for the patients who had between one and seven grades of schooling. Those completing the eighth grade were next with 52% not requiring rehospitalization. The other male groups came below the 49.2% average for

for that sex. Those with no education came at the lowest extreme with all the patients being readmitted to a mental hospital. With only three patients included, no conclusions can be drawn from this result. The next lowest rate was 28.6% of the seven male patients in the 9-11 grade group.

The females (Table 16) showed the highest rates in the extremes. Both these with more than high school education and with no schooling at all showed the high rate of 80% remaining outside in the community without rehospitalization. Each of these rates was computed on a basis of five patients and therefore cannot be given much weight. With these eliminated, there remained only one group with a readjustment rate above the 57.5% average for the females. This was 58.8% for the eighth grade interval. Among the females the 9-11 class showed the smallest proportion of readjustments: 42.8%.

Not considering the rates which were based on inadequate sampling, it can be concluded that the patients who went through grammar school and no further showed the highest rates of readjustment. They were higher than the average for each sex. The poorest readjustment was made by the patients who went on to secondary school but never completed it. Would an analysis of the reasons why these patients had to terminate their education be helpful in

determining why they also needed further hospitalization?

Because of the wide scatter and small frequency within many classes, the patients were grouped into but three intervals -- over eighth grade, eighth grade, and under eighth grade -- when the readjustment rates of social service and non-service patients were computed. Both male and female patients in the eighth grade show a decidedly lower percentage of readjustment when they were followed by social service as compared with the non-service patients (Tables 17, 18). The rates under social service were: males, 42.7% and females, 53.6%. Non-service patients in the same grade levels had the following rates of readjustment: 61.5% males and 83.3% for the females. The opposite occurred in the over and under eighth grade intervals except in one instance. Female non-service patients with less than eighth grade education showed a higher rate of readjustment as compared with the social service patients of the same educational status. The former rate is questionable as it was determined from four cases only.

When the readjustment rates of the three types of social services were determined, they also showed for the most part that middle group of eighth grade graduates had a lower rate of adjustment than the patients below or above this class. This evidence is, however, supported by only a small sample and therefore, cannot be considered con-

clusive.

These comparative rates indicate that patients with less than eighth grade education or with nine grades or more adjusted better under social service. Those whose highest grade in school was the eighth showed the poorest readjustment under social service. Although there does not seem to be any connection between the rate of adjustment and the proportion of each school grade group followed by social service, these differences in readjustment lead one to question the bases on which cases for social service were selected and the importance these may have had in determining whether or not the patients were rehospitalized.

Summary: Patients who completed the eighth grade and went no further in school had the highest rate of readjustment in both sexes. Poor readjustments were made by patients who started but did not complete their high school courses. Male patients who had less than grammar school education likewise had a high incidence of readmissions. Patients selected by social service made poorest readjustments in the eighth grade as compared with those above or below this school grade. Non-service patients' readjustment rates were the reverse of social service.

Did the patients with only eight grades of schooling have more insight into their limitations or were their ob-

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jectives more realistic than the other patients'? Would the patients within the upper educational levels benefit from social service assistance more than would those who had little education?

Table 16: Number and Percent of Patients Readjusted in Each School Grade Group by Sex.

School Grade Completed	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 12	2	40.0	4	80.0	6	60.0
12	2	100.0	11	50.0	13	54.2
9 - 11	2	28.6	3	42.8	5	35.7
8	13	52.0	20	58.8	33	55.9
1 - 7	8	53.3	5	50.0	13	52.0
None	0	.0	4	80.0	4	50.0
Unknown	3	75.0	3	75.0	6	75.0
Average	30	49.2	50	57.5	80	54.0

Table 17: Number and Percent of Male Patients Readjusted in Each School Grade Group by Service.

School Grade Completed	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 8	2	50.0	4	40.0	6	42.9
8	5	42.7	8	61.5	13	52.0
Under 8	7	58.3	1	16.7	8	44.4
Unknown	1	50.0	2	100.0	3	75.0
Average	15	50.0	15	48.5	30	49.2

Table 18: Number and Percent of Female Patients Readjusted in Each School Grade Group by Service.

School Grade Completed	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 8	10	62.5	8	44.4	18	53.0
8	15	53.6	5	83.3	20	58.8
Under 8	6	54.5	3	75.0	9	60.0
Unknown	3	75.0			3	75.0
Average	34	57.7	16	57.2	50	57.5

VI - ECONOMIC STATUS

Does economic insecurity reduce the patient's possibility of readjusting to the community? The basis on which an answer was sought to this question was the economic status listed on the face sheet of each patient's record. Whether or not these classifications truly represent a degree of economic security is debatable. The classifications are admittedly subjective. Although an attempt is made to ascertain the family income of each patient, there are no rigid income levels to guide the many psychiatrists determining the economic status. In spite of these limitations, do the dependents have more difficulty in readjusting?

DISTRIBUTION - Only one patient out of the 148 sampled was considered to be economically "comfortable" (Table 19). The remainder were either dependent or marginal. The majority - 77.7% - were in the latter class. There were more male dependents than female -- 24.6% to 17.3%.

The economic distribution of social service patients showed a higher portion in the dependent class than did

Table 19: Economic Status and Sex.

Status	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Dependent	15	24.6	15	17.3	30	20.3
Marginal	45	73.7	70	80.4	115	77.7
Comfortable	1	1.7			1	.7
Unknown			2	2.3	2	1.3
Total	61	100.0	87	100.0	148	100.0

Table 20: Economic Status of Social Service and Non-Service Male Patients.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Dependent	9	30.0	6	19.3	15	24.6
Marginal	20	66.7	25	80.7	45	73.7
Comfortable	1	3.3	—	—	1	1.7
Total	30	100.0	31	100.0	61	100.0

Table 21: Economic Status of Social Service and Non-Service Female Patients.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Dependent	15	25.5			15	17.3
Marginal	43	72.8	27	96.4	70	80.4
Unknown	1	1.7	1	3.6	2	2.3
Total	59	100.0	28	100.0	87	100.0

Table 22: Percent of Each Economic Status Aided by Social Service.

Status	Male	Female	Total
Dependent	60.0	100.0	80.0
Marginal	44.5	61.5	54.7
Average	49.2	68.7	60.1

the non-service. Among the males this difference between social service and non-service was slightly less marked (Table 20). Here the portions were 30% and 19.3% respectively. However, while there were no dependent females leaving the hospital in the non-service group, this economic group comprised 25.5% of the female social service (Table 21).

Thus while 100% of the dependent females were followed by social service, only 60% of the males in the corresponding economic class received the service (Table 22). Of the marginal group less than the average for each sex had social service.

Another difference was that dependent patients under social service formed a higher portion of the intensive case group than family care or visit resource. For the marginal social service patients the order was in reverse, with visit resource having the largest percentage. The types of social service were not analyzed for each sex as the sample was inadequate.

Summary: One-fourth of the males and less than a fifth of the females were classified as being economically dependent. All but one of the remainder were in the marginal class. Social service followed a higher portion of the dependents than the marginals. All of the female dependents

received some form of social service, but only six-tenths of the males of the same status. Under social service the dependent class was predominantly in the intensive case group, while the marginal was mostly in the visit resource.

READJUSTMENT - The rate of readjustment for those of marginal status was 58.2%, and 43.3% for the dependents (Table 23). The difference was wider among the males than the females. Only one-third of the male dependent class remained without rehospitalization for three years. In the same class the rate of readjustment for the females was 53.3%. Could the fact that all of the patients of the latter sex received social service account for this difference? Or may the connotation of dependency differ between sexes? In the marginal class, which was more equally followed by social service, there is a smaller variation between the female and male rates of readjustment. Fifty-five and six-tenths percent of the males in this economic level readjusted to the community, while 60% of the females did likewise. This evidence apparently supports the hypothesis that dependency tends to reduce the rate of readjustment.

Since there were no dependent females in the non-service group, the total figures for social service cannot be validly compared with non-service. The males of these

two services showed very similar results (Table 24). Both the social service and non-service males had rates of one-third readjusted. In the marginal group, however, the non-service rate of 52% was slightly below the 60% of social service.

The females of the marginal level (Table 25) showed even less difference between the services: 60.5% for social service, and 59.2% for non-service (Table 28). The social service rate of adjustment for dependents was, of course, the same as the female rate or 53.3%.

In comparing the individual types of social service, it was seen that although more of the dependents received intensive case, this economic group had a higher rate of readjustment in the visit resource group. The rate of the latter was 57.1% as compared with 40% for the intensive. The results for the marginal group were antithetical. Its highest rate was 72.2% for the intensive case category, the category in which there was the smallest proportion of marginal patients.

The two cases whose economic level was unknown were rehospitalized, accounting for the fact that the non-service average rate is 57.2%. The male patient who was the sole individual in the comfortable group received social service, but likewise did not readjust.

Summary: The patients with marginal income showed a higher rate of readjustment than those who were classified as dependent, especially among the males. This also occurred under social service. The dependents followed by social service had the highest rate of readjustment in the visit resource group as compared with family care and intensive case work. The marginal group readjusted best when intensive service was given.

Does low economic status then tend to produce insecurity which retards readjustment following hospitalization for mental disorder? If so, is not this the area in which the social worker can be helpful?

Table 23: Number and Percent of Patients Readjusted in Each Economic Status by Sex.

Status	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Dependent	5	33.3	8	53.3	13	43.3
Marginal	25	55.6	42	60.0	67	58.2
Average	30	49.2	50	57.6	80	54.0

Table 24: Number and Percent of Male Patients Readjusted in Each Economic Status by Service.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Dependent	3	33.3	2	33.3	5	33.3
Marginal	12	60.0	13	52.0	25	55.6
Average	15	50.0	15	48.5	30	49.2

Table 25: Number and Percent of Female Patients Readjusted in Each Economic Status by Service.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Dependent	8	53.3			8	53.3
Marginal	26	60.5	16	59.2	42	60.0
Average	34	57.7	16	57.2*	50	57.5

* Both patients of unknown economic status were rehospitalized, which accounts for this average rate of readjustment.

VII - MARITAL STATUS

> The married have the least chance of developing mental disorders of any of the marital groups. The widowed, the single, and the divorce, in order, show a higher incidence of mental disorders...The males seem to be benefited to a greater extent than the females...by marriage.[1]

These results determined from rates of admissions on the basis of corresponding population indicate that marital status and mental disorder are interrelated. Perhaps marriage is a protective factor, or could it be that the persons who marry and remain so are inherently stable? Whatever the reason, the marital statuses were compared here according to degree of readjustment of the individuals.

DISTRIBUTION - In the sample there were fewer married males than married females (Table 26). in the proportions of 23% to 46%. Two-thirds of the males were single. Among the opposite sex there were only 35.6% single, less than the married group. In the "other" status there were 18.4% of the females and nine and eight-tenths percent of the males. This group included eight widowed, six divorced,

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[1] Dayton, op. cit., pp. 203-204.

five separated, and three unknown. All of these except the last were thus of the marriage types that had the highest indices of mental illness in the study just quoted.

The single patients appeared in proportionately large numbers in both the male social service and male non-service (Table 27). In the former they were 56.7% of the total and 77.4% of the latter. One-third of the male social service patients were married, but only 12.9% of the non-service. On the female services the largest groups were 49.2% of social service married and 53.6% of the non-service single (Table 28).

This means that a little better than 70% of the married patients of both sexes were assisted by social service (Table 29). Of the single males, 41.5% and of the single females 51.6% were given this service. Social service also followed half of the males in the "other" classification and 87.5% of the females in the corresponding group.

In most cases the married group when followed by social service was given aid in arranging visit resources, and family care in the fewest instances. The single patients were mostly placed in family care homes, and rarely given visit resource service. The types of social service received by the "other" marital status were, in order, intensive case, family care and visit resource.

Table 26: Marital Status and Sex.

Status	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Single	41	67.2	31	35.6	72	48.7
Married	14	23.0	40	46.0	54	36.4
Other*	6	9.8	16	18.4	22	14.9
Total	61	100.0	87	100.0	148	100.0

* Includes: 8 widowed, 6 divorced, 5 separated, and 3 unknown.

Table 27: Marital Status of Social Service and Non-Service Male Patients.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Single	17	56.7	24	77.4	41	67.2
Married	10	33.3	4	12.9	14	23.0
Other	3	10.0	3	9.7	6	9.8
Total	30	100.0	31	100.0	61	100.0

Table 28: Marital Status of Social Service and Non-Service Female Patients.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Single	16	27.1	15	53.6	31	35.6
Married	29	49.2	11	39.3	40	46.0
Other	14	23.7	2	7.1	16	18.4
Total	59	100.0	28	100.0	87	100.0

Table 29: Percent of Each Marital Status Aided by Social Service.

Status	Male	Female	Total
Single	41.5	51.6	45.8
Married	71.5	72.5	72.2
Other	50.0	87.5	77.2
Average	49.2	68.7	60.1

Summary: The married group was largest among the females. Among the males the largest proportion were single. More of the males were single than of the females. The group including the divorced, separated, and widowed was larger among the females than the males. These proportions were the same for male and female social services. A higher portion of the married and "other" statuses than of the single group were followed by social service. The married patients followed by social service in most cases were visit resource; single patients, family care; and "other" patients, intensive case.

READJUSTMENT - The rates of readjustment for the total number studies were: 77.2% for the "other" status; 57.4% for the married; and 44.5% for the single (Table 30). This order was the same for both males and females. The results are somewhat surprising as the "other" group, which included marriage types that have the highest rates of mental illness, readjusted considerably better even than the married group. Could it be that the married patients were returning to home conditions which had precipitated their mental disorder?

Both in the male social service and non-service patients the rates of readjustment followed the "other"-married-single pattern (Table 31). Since the percents were computed

from small samples, the exact figures need not be quoted. It is the order of adjustment, rather, that is important.

Neither the female social service nor non-service groups readjusted similarly (Table 32). The married female patients who received social service readjusted most poorly, for they had a rate of only 43.3%. This same marital group showed the highest rate of readjustment, 88.9%, under the non-service category. The causative factors behind these differences certainly should be studied by psychiatric social workers.

Comparisons of rate of readjustment for intensive case, family care, and visit resource types of social service did not reveal any outstanding trends.

Summary: The marital group readjusting with the highest rate was that which included the divorced, separated, and widowed. Both males and females who were married were next in order, with the single patients showing fewest readjustments. Male social service and non-service groups readjusted in similar order. Female social service patients who were married readjusted most poorly. Non-service patients of the same sex and marital status had the highest rate of readjustment.

What factors besides marital status correlate with the

higher readjustment rates for the married patients as compared with the single? If marriage serves as a protective force, can any social service be given single patients which would compensate for the absence of such?

Table 30: Number and Percent of Patients Readjusted in Each Marital Status by Sex.

Status	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Single	17	41.5	15	48.4	32	44.5
Married	8	57.2	23	57.5	31	57.4
Other	5	83.3	12	75.0	17	77.2
Average	30	57.5	50	57.5	80	54.0

Table 31: Number and Percent of Male Patients Readjusted In Each Marital Status by Service.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Single	7	41.2	10	41.7	17	41.5
Married	6	60.0	2	50.0	8	57.2
Other	2	66.7	3	100.0	5	83.3
Average	15	50.0	15	48.5	30	49.2

Table 32: Number and Percent of Female Patients Readjusted in Each Marital Status by Service.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Single	10	62.5	5	33.3	15	48.4
Married	13	43.3	10	88.9	23	57.5
Other	11	78.6	1	50.0	12	75.0
Average	34	57.7	16	57.2	50	57.5

VIII - HOSPITALIZATION

It was assumed for this study that hospitalization and the degree to which a patient is mentally disordered have a positive correlation. Of course, it was recognized that other factors besides the mental illness determined the length of time a patient would remain in a hospital. The intensity and type of treatment are important factors. Often visit resources cannot be arranged or are not available just as soon as the patient is sufficiently recovered to return to the community. Relatives may refuse to assume the responsibility of supervising a patient. But generally the hospital succeeds in its purpose to return a patient to the community as soon as he is able. The need for beds, because of a fairly constant rate of admissions, virtually guarantees this.

The problem of this section was to see whether or not the patients readjusted as well regardless of hospitalization. There were three bases upon which such a question could be answered: the length of this admission; total length of hospitalization including previous admissions; or just the number of readmissions. If the last had been

used it would have only partially indicated the need for repeated treatment, for a patient is not considered "readmitted" unless he has been discharged after a year's trial period. Thus a patient would still be listed a "first admission" no matter how often he had been discharged "on visit" and had failed to remain out of the hospital for the full year period. By using only the length of this hospitalization, the patients who required repeated treatment would be disregarded. Thus total hospitalization statistics, excluding the visit periods, were selected for analysis. The results of all three sets of hospitalization data, however, correlated as will be shown later.

DISTRIBUTION - The scatter of patients according to total length of hospitalization was extremely wide. It ranged from one month to 50 years. Yet, 54.7% of both sexes was hospitalized for only a year or less (Table 33). The males showed a larger proportion having less than six months hospitalization than did the females. The percentages were 39.4 and 31.1 respectively. Only 14.7% of the males were in a mental hospital from six through 12 months; while 24.1% of the females were admitted for the same length of time. In the 13-24 months group there were 21.3% of the males and 14.9% of the females. Nearly 30% of the females were hospitalized more than two years for mental

disorders, but only 24.6% of the males.

This tendency for the female patients to remain longer in a mental hospital than the males was corroborated by figures on the average length of time each sex was hospitalized (Table 37). The males, on the average, stayed in the institution for 21.2 months, but the female patients remained for over a year longer. Their average was 34.6 months.

Among the males alone, it was found that but one-third of the social service patients were hospitalized for less than six months (Table 34). Whereas 45.2% of the non-service were in the hospital same duration. Approximately one-fourth of the social service males were hospitalized from six to 12 months group and also from 13 to 24 months. Among the non-service, only 6.5% were in the former, and 16.1% in the latter. Thirty-two and three-tenths percent of the non-service male patients were in a hospital for more than two years. Only half of that proportion of the social service were likewise kept in the hospital longer than two years. Consequently the social service male patients averaged but 15 months hospitalization as compared with 27.2 for the non-service (Table 37).

The proportions of hospitalization groups for social service and non-service female patients were nearly identical

and followed the same order, namely: under six months; over 24 months; six to 12 months; and 13-24 months (Table 35). Thirty and a half percent of the social service were in each of the first two groups. Of the non-service, 32.1% were in the first and 28.6% in the second. Those of this sex followed by social service were hospitalized for 36.6 months on the average, or a half year more than the non-service females (Table 37). This is in contrast to the male statistics. The reason perhaps lies in the extremely high length of hospitalization among the female patients placed in family care homes.

When the incidence of social service within each hospitalization group was computed, it was evident that the six to 12 months group had the highest percentage in both sexes (Table 36). The incidence of social service within this group was 73.3%. The 13-24 months group with 61.5% under social service was also above the male average. Female patients remaining in a hospital more than 24 months received social service in 69.2% of the cases, which was the only other group above the female average. This same hospitalization group showed the smallest proportion of social service on the male side. Only one-third of these male patients received the service. The lowest rate on the female side was in the 13-24 months group which had

Table 33: Total Length of Hospitalization and Sex.

Months Hospitalized	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 24	15	24.6	26	29.9	41	27.7
13 - 24	13	21.3	13	14.9	26	17.6
6 - 12	9	14.7	21	24.1	30	20.2
Under 6	24	39.4	27	31.1	51	34.5
Total	61	100.0	87	100.0	148	100.0

Table 34: Total Length of Hospitalization of Social Service and Non-Service Male Patients.

Months Hospitalized	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 24	5	16.7	10	32.3	15	24.6
13 - 24	8	26.6	5	16.1	13	21.3
6 - 12	7	23.3	2	6.5	9	14.7
Under 6	10	33.3	14	45.2	24	39.4
Total	30	99.9	31	100.1	61	100.0

Table 35: Total Length of Hospitalization of Social Service and Non-Service Female Patients.

Months Hospitalized	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 24	18	30.5	8	28.6	26	29.9
13 - 24	8	13.5	5	17.8	13	14.9
6 - 12	15	25.4	6	21.4	21	24.1
Under 6	18	30.5	9	32.1	27	31.1
Total	59	99.9	28	99.9	87	100.0

Table 36: Percent of Each Hospitalization Group Aided by Social Service.

Months Hospitalized	Male	Female	Total
Over 24	33.3	69.2	56.2
13 - 24	61.5	61.5	61.5
6 - 12	77.7	71.4	73.3
Under 6	42.7	66.7	55.0
Average	49.2	67.8	60.1

Table 37: Average Length of Hospitalization in Months by Service and Sex.

Service	Male	Female	Total
		(Number of Months)	
Intensive Case	9.6	11.6	10.8
Family Care	14.9	93.7	62.7
Visit Resource	26.9	14.4	16.8
Social Service	15.0	36.6	29.3
Non-Service	27.2	30.5	28.7
Average	21.2	34.6	29.1

61.5%. Thus the difference between the group receiving the highest proportion of social service and the lowest was only one-fourth as great on the female side as among the males. Is there any reason for this extreme variation? Does the additional social service among the females account for the higher rate of readjustment for that sex as compared with the males?

When the types of social services offered were compared, the results showed that the intensive cases had the shortest average hospitalization period (Table 37). Could it be that the psychiatric social workers judged that patients whose mental disorders were mildest could most benefit from intensive treatment? Is such an assumption justified?

Summary: A slight majority of the patients leaving the mental hospital in 1938 had had only a year or less of hospitalization. The females tended to have longer periods of hospitalization than the males. Male social service patients remained in the hospital less than the non-service; and vice versa for the female patients. In both sexes the patients in the six to 12 months of hospitalization group had the highest proportion of social service. The intensive cases were hospitalized less than family care or visit resource patients.

READADJUSTMENT - Patients hospitalized less than six months and 13-24 months showed rates of readjustment higher than the average for each sex (Table 38). Only one-third of the males and females hospitalized for less than six months did not remain in the community for three years after release from the mental hospital. Those hospitalized 13-24 months had the following rates of readjustment: 77% females; 61.5% males. Below the male average were: six to 12 months, 33.3%; and over 24 months, 20%. The females showed the same order, but each group had a higher percentage: 57% and 38.4% respectively. Although these figures do not show an inverse relation between hospitalization and readjustment, it is clear that patients remaining in the mental hospital over two years had the least chance of remaining in the community after their release.

A question that did arise from these data is: why did the patients remaining 13-24 months show such a high rate of readjustment? When previous hospitalizations were eliminated the same order of readjustment occurred. In comparing just the number of readmissions and the rate of readjustment, the two showed an inverse ratio. While 58.3% of the patients who had no previous admissions readjusted, 26.3% of those who had three or more readmissions did the same. If the latter statistics had shown a high rate of readjustment after the second or third recommittment, the

assumption may have been made that these patients had not previously been given sufficient hospitalization and treatment. Since this was not the case, the explanation probably lies elsewhere.

Following this inexplicable pattern, under social service three-fourths of both sexes in the 13-24 months interval readjusted (Tables 39, 40). This was the highest rate of readjustment for the male social service patients. The females receiving social service, however, readjusted even better in the group which had stayed on the wards less than six months. This rate was 77.8%. The corresponding male group readjusted in only half the cases, the average for that sex. The poorest rate among the males was among those who had been in the mental hospital more than a couple of years. Of these but one-fifth readjusted to the community for three years. The females' rate of readjustment was 44.4% for the same group, or more than double that of the males. The lowest female social service rate was 40% for the patients in the six to 12 months interval. Can the higher rate for the females having over two years of hospital care as compared with the males receiving an equal amount of hospitalization be related to the more uniform and higher percent of social service (Table 35) between the various intervals in the former sex?

The non-service patients showed a number of deviations from those receiving social service. However, these were evidently in cases where the sample was too small to make any conclusive statements (Tables 39, 40). With these eliminated, the order of readjustment seems to be similar for both social service and non-service. The individual types of social service likewise tended to follow this pattern.

Summary: Patients hospitalized less than six months and 13-24 months readjusted better than the average for each sex. Lowest rate of readjustment for males and females was in the group under hospital care for more than two years. The social service and non-service hospitalization groups were distributed above and below the averages for each sex in virtually the same order. Number of readmissions and rates of readjustment were in reverse ratio to each other.

Why is it that female patients show a higher rate of readjustment in spite of a longer period of hospitalization? Can it be that the additional treatment better prepared them for readjustment in the community? Or were the social factors to which they returned significantly different?

Table 38: Number and Percent of Patients Readjusted in Each Hospitalization by Sex.

Months Hospitalized	Male No.	Male P.C.	Female No.	Female P.C.	Total No.	Total P.C.
Over 24	3	20.0	10	38.4	13	31.7
13 - 24	8	61.5	10	77.0	18	69.2
6 - 12	3	33.3	12	57.0	15	50.0
Under 6	16	66.7	18	66.7	34	66.7
Average	30	49.2	50	57.5	80	54.0

Table 39: Number and Percent of Male Patients Readjusted in Each Hospitalization Group by Service.

Months Hospitalized	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 24	1	20.0	2	20.0	3	20.0
13 - 24	6	75.0	2	40.0	8	61.5
6 - 12	3	42.8	0	.0	3	33.3
Under 6	5	50.0	11	78.6	16	66.7
Average	15	50.0	15	48.5	30	49.2

Table 40: Number and Percent of Female Patients Readjusted in Each Hospitalization Group by Service.

Months Hospitalized	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 24	8	44.4	2	25.0	10	38.4
13 - 24	6	75.0	4	80.0	10	77.0
6 - 12	6	40.0	6	100.0	12	57.1
Under 6	14	77.8	4	44.4	18	66.7
Average	34	57.7	16	57.2	50	57.5

IX - DIAGNOSIS

That the rates and degrees of recovery for the various psychoses differ cannot be disputed. This analysis of patients according to psychosis and rate of readjustment was done in an effort to determine if those patients followed by social service showed any significant differences as compared with the non-service patients.

Since in many of the classifications of psychoses the number of patients was very small, the following groupings were made. Both dementia praecox and schizophrenia, in all their various sub-forms, were grouped together. Also all the psychoses which "involve actual destruction of nervous structure in the brain"[1] were classified as organic. The alcoholic psychoses need no further defining. The manic depressive and involutional psychoses were combined into the affective group, which is defined as a "form of personality disorder in which the essential characteristics are disorders of mood."[2] The other forms of psychoses were

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[1] George W. Henry, Essentials of Psychiatry (Baltimore: Williams and Wilkins, 1938), p. 177.

[2] *Ibid.*, p. 54.

not classified.

DISTRIBUTION - The distribution of the various psychoses in the sample deviates far from what is normally expected on the basis of the mental health statistics in Massachusetts (Table 41). Whereas schizophrenics composed only a little over one-fourth of the patients admitted with mental disorder during 1938,[3] this sample of patients returning to the community taken from the same year showed 39.2% with similar mental disorder. Perhaps the fact that Worcester State Hospital is carrying on intensive research of schizophrenia and the increased use of metrazol shock treatments explain this high number of schizophrenics. In the sample the organic psychoses were 14.8% of the total which was almost proportionate to that of the admissions. The alcoholic psychoses numbered 10.8% of the total sample; but the proportion among admissions with mental disorder was almost double that. In the affective group the difference is even wider. Over a fourth of the admissions were within this group, but only 15.6% of the patients sampled. Approximately one-fifth of the patients studied had diagnoses which were grouped in the "other" classifica-

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[3] Percentage figures for admissions were computed on basis of statistics for all mental hospitals of Massachusetts as given in the Report of the Commissioner of Mental Health (November, 1938), p. 172.

tion as the frequency in each was too small to be considered individually.

Sex differences were most marked in the alcoholic and affective groups (Table 41). Of the male patients leaving the hospital 22.9% had been diagnosed as having an alcoholic psychosis. Only one-tenth of that percentage of the females were similarly diagnosed. Almost five percent of the males had some form of affective psychosis, as compared with 23% of the females having comparable disorders.

The distribution of psychoses among the male social service patients was schizophrenia 26.6% and alcoholism 36.7% (Table 42). Fifty-four and eight-tenths percent and 9.7% were the respective proportions under the non-service category. In other words, only 32% of the schizophrenics received social service as compared with 78.6% of those with alcoholic psychoses.

Female social service and non-service patients showed different proportions in the organic and the affective psychoses (Table 43). In the former group there was 22% under social service and but 3.6% under non-service classifications. The percentages for the affective psychoses were: 18.7% social service and 32.1% non-service.

Of all the female groups, the organic psychoses received most social service. Thirteen out of the fourteen

Table 41: Diagnosis and Sex.

Psychosis	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Schizophrenic	25	41.0	33	37.9	58	39.2
Affective	3	4.9	20	23.0	23	15.6
Organic	8	13.1	14	16.1	22	14.8
Alcoholic	14	22.9	2	2.3	16	10.8
Other	11	18.1	18	20.7	29	19.6
Total	61	100.0	87	100.0	148	100.0

Table 42: Diagnosis of Social Service and Non-Service Male Patients.

Psychosis	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Schizophrenic	8	26.6	17	54.8	25	41.0
Alcoholic	11	36.7	3	9.7	14	22.9
Other	11	36.7	11	35.5	22	36.1
Total	30	100.0	31	100.0	61	100.0

Table 43: Diagnosis of Social Service and Non-Service Female Patients.

Psychosis	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Schizophrenic	21	35.6	12	42.9	33	37.9
Affective	11	18.7	9	32.1	20	23.0
Organic	13	22.0	1	3.6	14	16.1
Other	14	23.7	6	21.4	20	23.0
Total	59	100.0	28	100.0	87	100.0

patients with this diagnosis were given the service. Next came the "other" group of which 70% received social service. The other psychoses received less than the average percentage of social service for the sex.

Summary: Two-fifths of both male and female patients were schizophrenic. The alcoholic psychoses were almost one-fourth of the male diagnoses; and similarly the affective of the female. An average of 15% for both sexes had an organic psychosis. Chief sex differences based on percentages were one-tenth as many female alcoholics as male; and five times as many female patients with affective psychoses as male. Among the males, the alcoholic psychoses received the highest proportion of social service. The female social service was directed primarily at the organic and "other" groups.

READJUSTMENT - Because of the size of the sample, a comparison between female and male readjustment within a specific psychotic group could only be made for the schizophrenics (Tables 44, 45). Of the males with this psychosis 48% readjusted; and of the females, 54.6%. Thus the difference in sex does not appear to be very significant for the readjustment of patients with psychoses of schizophrenia.

Half of the male alcoholic and "other" psychoses remained in the community (Table 44). These rates were just

slightly above the average readjustment rate for the sex.

The highest and only readjustment rate above the female average was that of the affective psychoses (Table 45). Three-fourths of the patients with these diagnoses remained in the community for the full three years. The second rate was that of the schizophrenics, already mentioned. The organic and "other" psychoses each recovered in one out of every two instances.

No significant differences could be deducted from a comparison of the social service and non-service patients as the latter were too few in number within the specific psychosis groups (Tables 44, 45). However, when the rates of readjustment for social service and the total rates for each sex were compared psychosis by psychosis the former were alightly higher in six of the seven groupings. The exception was the male alcoholic psychosis.

Summary: Female schizophrenics readjusted slightly better than male. Half of the male alcoholic and "other" psychoses readjusted. Three-fourths readjusted was the rate of the female affective psychoses, which was the only group above the average rate of readjustment for that sex. The female organic and "other" groups remained in the community in half the instances; while the female schizophrenics did so in 54.6% of the cases. Social service patients re-

adjusted better than non-service in all the psychoses groups except the male alcoholic.

Why do the affective psychoses show such a high rate of readjustment? Is the low rate of the organic psychoses due primarily to deterioration? Could the readjustments of the male schizophrenics have been increased by more intensive social service assistance?

Table 44: Number and Percent of Male Patients Readjusted in Each Diagnostic Group by Service.

Psychosis	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Schizophrenic	4	50.0	8	47.1	12	48.0
Alcoholic	5	45.5	2	66.7	7	50.0
Other	6	54.5	5	45.5	11	50.0
Average	15	50.0	15	48.5	30	49.2

Table 45: Number and Percent of Female Patients Readjusted in Each Diagnostic Group by Service.

Psychosis	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Schizophrenic	12	57.2	6	50.0	18	54.6
Affective	9	81.8	6	66.7	15	75.0
Organic	7	53.8	0	.0	7	50.0
Other	6	42.8	4	66.7	10	50.0
Total	34	57.7	16	57.2	50	57.5

X - AGE

As the person's age changes, so must his life. The period from birth to the teens normally is characterized by the gradual decreasing dependence upon parents and increased self-sufficiency. Between the ages of 20 and 50 most persons have assumed roles of responsibility as breadwinners, mates, parents. In the late years of life the adult's position reverts to one of dependence as his ability to earn a livelihood diminishes. Recognizing that this process and the personal attitudes involved differ from individual to individual, this study of age and readjustment of patients after leaving the mental hospital was undertaken to determine if any age group difference in ability to remain in a community were present.

DISTRIBUTION - Subdividing the sexes into intervals of a decade each resulted in a fairly normal curve of distribution (Table 46). The modal interval for males and females was 30-39 years. The proportion of females in each of the intervals above 39 years of age was greater than that of the males; and vice versa below that. Thus the average

age for the females was three years higher than that of the opposite sex. Their respective averages were: 40.1 and 43.4 years (Table 49). Is this because female patients require longer hospitalization? Or can it be that readjustments are most difficult for the males at an earlier age than for the females? Another question that could be asked is, do the strains to which each sex is subjected differ? Which of them could be alleviated by social service?

Comparing the total numbers under social service and non-service classifications it is clear that the former had a higher percent in each of the decades above 39 years but not below that year (Table 47). This was true of both sexes. The ratio between age and social service among the female patients was inverse (Table 48). Although this did not exactly hold true for the males, those 40 years or older received social service in more than 49.2% of the total cases in each decade. Those younger than 40 received less than the average amount of social service for that sex.

The average ages of the social service patients was consequently higher than those of the non-service (Table 49). For the males these were 42.1 and 38.1 years in order. The difference was even greater among the females. Social service female patients were on the average aged 47 years old, but the non-service patients were close to 11 years their juniors.

Table 46: Age on Leaving the Hospital and Sex.

Years	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 59	8	13.1	13	14.9	21	14.2
50 - 59	8	13.1	17	19.5	25	16.9
40 - 49	11	18.1	18	20.7	29	19.6
30 - 39	18	29.5	23	26.4	41	27.7
20 - 29	13	21.3	13	14.9	26	17.6
Under 20	3	4.9	3	3.5	6	4.0
Total	61	100.0	87	99.9	148	100.0

Table 47: Age on Leaving the Hospital of Social Service and Non-Service Patients; Both Sexes Included.

Years	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 59	16	18.0	5	8.5	21	14.2
50 - 59	20	22.4	5	8.5	25	16.9
40 - 49	19	21.4	10	17.0	29	19.6
30 - 39	19	21.4	22	37.2	41	27.7
20 - 29	13	14.6	13	22.0	26	17.6
Under 20	2	2.2	4	6.8	6	4.0
Total	89	100.0	59	100.0	148	100.0

Table 48: Percent of Each Age Group Aided by Social Service.

Years	Male	Female	Total
Over 59	50.0	92.3	76.2
50 - 59	87.5	76.5	80.0
40 - 49	54.5	76.5	65.5
30 - 39	33.3	56.5	46.3
20 - 29	46.1	53.8	50.0
Under 20	33.3	33.3	33.3
Average	49.2	67.8	60.1

Table 49: Average Age on Leaving the Hospital by Service and Sex.

Service	Male	Female	Total
		(Number of Years)	
Intensive Case	43.6	42.3	42.9
Family Care	41.7	51.4	47.6
Visit Resource	40.0	46.9	45.6
Social Service	42.1	47.0	45.5
Non-Service	38.1	36.1	37.2
Average	40.1	43.4	42.2

The most aged group according to type of service among female patients was family care, which averaged 51.4 years. The male intensive cases were the oldest group as compared with family care and visit resource. Of the female social service, the intensive cases were younger than the other two types of service. In spite of this, the female and male intensive cases differed only slightly in average age: 42.3 and 43.6 years respectively. What were the other social factors which influenced this selection by social service?

Summary: Female patients were older than the male patients at the time they left the mental hospital. Social service patients were older than non-service of both sexes. Patients above the age of 39 receive a higher percentage of social service than those that age or younger. Of the types of social service the intensive cases were the youngest on the female side and oldest on the male.

READJUSTMENT - Based on decade age groups, male patients above the age of 49 years showed a higher rate than those under that age (Table 50). This was not quite the case among the females. In the twenties, thirties, and forties, the males had almost consistent rates of readjustment, averaging 45.2%. During the same decades the females had

rates which varied from 47.8% readjusted in the years 30-39 to 69.2% in the 20-29 interval. The highest female rate of readjustment, however, was 76.5% for those in their fifties.

Since some of the variations may be due to the small frequencies within the class intervals, the patients were combined into but two age groups: 20-49 years and over 49 years. These figures showed that in both sexes the rates of readjustment were higher in the later years. Males younger than 50 had a rate of 45.2% readjusted. Females of the same age group readjusted 55.5%. The rates for patient over 49 were: 62.5%, males; 66.7% females. Since the female patients were older than the males and older patients tend to readjust better than the younger, can the higher rate of readjustment for the former sex be ascribed to the age factor? Were the social pressures which the middle aged and elderly patients faced upon leaving the hospital significantly different?

With social service concentrated more on the old than the younger patients, the readjustment rates of both male and female social service patients showed the same indirect ratio between readjustment and age (Table 51). In the 20-49 year group social service patients and non-service patients were nearly equal. The rates were 53% readjusted

of the social service, and 48.9% of the non-service. The non-service patients older than 49 years had the unusually high rate of 90% which in all probability was due to the fact that only 10 patients were in this interval.

Summary: Patients fifty years or older showed a higher rate of readjustment than those younger. This was true of both sexes, whether they received social service or not.

What other factors produced this relation between age and readjustment? Were social stresses important in the poorer readjustment of the middle aged patients?

Table 50: Number and Percent of Patients Readjusted in Each Age Group by Sex.

Years	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 59	6	75.0	7	53.8	13	61.9
50 - 59	4	50.0	13	76.5	17	68.0
40 - 49	5	45.4	10	55.6	15	51.7
30 - 39	8	44.4	11	47.8	19	46.4
20 - 29	6	46.2	9	69.2	15	57.7
Under 20	1	33.3	0	.0	1	16.7
Average	30	49.2	50	57.5	148	54.0

Table 51: Number and Percent of Patients Readjusted in Each Age Group by Service; Both Sexes Included.

Years	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Over 49	21	58.3	9	90.0	30	65.2
20 - 49	27	53.0	22	48.9	49	51.1
Under 20	1	50.0	0	.0	1	16.7
Average	49	55.1	31	52.5	80	54.0

XI - VISIT RESOURCE

The term "visit resource" refers to the person assuming the responsibility of supervising the patient during the year trial period after leaving the hospital. This does not necessarily mean that the patient lives with the person. However, it connotes some interest by the party in the patient. The person supervising the patient is instructed to return the patient at anytime that he feels the latter is becoming dangerous to the community or has a relapse of mental disorder. If the patient remains in the community for a full year without further hospitalization in a mental institution, the person in whose care he left is asked for a report of the patient's readjustment and for recommendations regarding the discharge of the patient. Of course persons used as "visit resources" assume this responsibility to varying degrees.

The problem of evaluating visit resources is one which is frequently referred to social service by the staff. Through interviews with the patient and his relatives, through contacts with social agencies and other organizations in the community, the hospital social worker gathers

information about possible visit resources for the patient. Then a report is made to the staff with recommendations as to the best possible plan for the patient should he be discharged "on visit". Because visit resources are considered so important in the patient's period of readjustment and because evaluation of visit resources is a major part of social service, this analysis of readjustment and visit resources was made.

DISTRIBUTION - The largest proportion of males went on visit in charge of a parent (Table 52). Nearly 38% of the total did so. In contrast, more of the females returned to the community in charge of their husbands than of any other visit resource. This group, forming 35.6% of all females, was almost as large as that of males leaving in care of parents.

The next largest visit resource groups among the males were: 19.7% in care of siblings and 14.8% in care of wives. The order among the females was 18.4% sibling visit resources and 16.1% parent. The remaining visit resource groups, too small for comparison, included patients discharged in care of their self, to family care only, to their children, or to other persons such as friends, grandparents.

The extremely higher percentage of female patients leaving in care of husbands as compared with males returning to their wives must be considered along with the marriage statistics already analyzed (Table 26). Forty females were married at the time of hospitalization, while only 14 males had the same marital status. Over two-thirds of those married were discharged "on visit" to their mates.

Another interesting fact was that patients tended to leave in charge of the parent, sibling, or child of their own sex. Perhaps the "cause" for this would be worth further study by psychiatric social workers.

Patients leaving in care of their mates were the largest visit resource group under social service (Table 53). They formed 30.3% of the total. Whereas non-service patients showed the highest frequency in being supervised by their parents. Over two-fifths of the non-service patients were in this visit resource group.

Among both sexes, social service assisted about two-thirds of the patients leaving in care of their mates and only one-third of those signed out by parents (Table 54). In the sibling group, 33.3% of the male patients received social service and 62.5% of the female. The 83.7% of social service patients in the "other" classification is weighted by the fact that this group includes family care placements.

Table 52: Visit Resource and Sex.

Type	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Mate	9	14.8	31	35.6	40	27.0
Parent	23	37.7	14	16.1	37	25.0
Sibling	12	19.7	16	18.4	28	18.9
Self	6	9.8	6	6.9	12	8.1
Family Care	6	9.8	6	6.9	12	8.1
Child	3	4.9	6	6.9	9	6.1
Other	2	3.3	8	9.2	10	6.8
Total	61	100.0	87	100.0	148	100.0

Table 53: Visit Resource of Social Service and Non-Service Patients; Both Sexes Included.

Type	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Mate	27	30.3	13	22.0	40	27.0
Parent	12	13.5	25	42.4	37	25.0
Sibling	14	15.7	14	23.7	28	18.9
Other	36	40.5	7	11.9	43	29.1
Total	89	100.0	59	100.0	148	100.0

Table 54: Percent of Each Visit Resource Group Aided by Social Service.

Type	Male	Female	Total
Mate	66.7	67.8	67.5
Parent	30.4	35.7	32.4
Sibling	33.3	62.5	50.0
Other	76.5	88.5	83.7
Average	49.2	67.8	60.1

Summary: The highest proportion of the male patients left in charge of their parents. Female patients had the highest frequency in the group supervised by husbands. Low percentage of males leaving in care of mates as compared with females rests on the fact that fewer of the former were married at time of admission. Social service assistance was given primarily to patients returning to their mates.

READJUSTMENT - The patients who left either in care of a mate or a sibling had the highest rates of readjustment (Table 55). The former had a rate of 65% readjusted and the other, 64.2%. Both sexes showed uniform rates of readjustment in these groups. Poorest readjustments were made by patients who had been supervised by their parents. Only 35.2% of these patients did not return to a mental hospital within three years. Although the males appeared to have a lower rate of readjustment in this group than the females, the figures, being based upon very small frequencies, are not indisputable. The patients leaving the hospital in charge of "other" visit resources were about average in readjusting, for slightly more than half of them remained in the community for the full three year period.

Social service showed higher rates of readjustment

than non-service in the parent and sibling visit resource groups (Table 56). Could then the rates of the parent and sibling groups have been raised by more intensive study and assistance by social service?

Summary: Highest rates of readjustment were made by patients who left the hospital in care of a mate or a sibling. Poorest readjustments were made by those leaving under the supervision of parents. Social service patients readjusted better than non-service in the parent and sibling group, and less well in the mate and "other" groups.

After examining this data, it can well be asked if increased follow-up of patients cared for by their parents would have raised the number of readjustments within this visit resource group. Do parents tend to be less understanding than other visit resources, or are the patients, who return to their parents, less capable of meeting existing stresses in the home and in the community? Can a social worker help minimize the effects of the existing conditions?

Table 55: Number and Percent of Patients Readjusted in Each Visit Resource Group by Sex.

Type	Male		Female		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Mate	6	66.7	20	64.5	26	65.0
Parent	6	26.1	7	50.0	13	35.2
Sibling	8	66.7	10	62.5	18	64.2
Other	10	58.8	13	50.0	23	53.5
Average	30	49.2	50	57.6	80	54.0

Table 56: Number and Percent of Patients Readjusted in Each Visit Resource Group by Service; Both Sexes Included.

Type	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Mate	15	57.2	11	84.6	26	65.0
Parent	6	50.0	7	28.0	13	35.2
Sibling	10	71.4	8	57.2	18	64.2
Other	18	50.0	5	71.4	23	53.5
Average	49	55.1	31	52.5	80	54.0

XII - EMPLOYMENT

"Yes, but can your patients return to work after they leave the hospital?" is a question that is often asked of the staff of a psychiatric hospital by people in the community. The chief concern of the community is whether or not the patient can become self-sufficient, for if he doesn't, then the community will have to support him. The psychiatrist's interest, on the other hand, lies in the therapeutic values of employment. This is evidenced by the increased use of occupational therapy in mental hospitals.

Since the social worker is in large measure the intermediary between the mental hospital and the community, both questions were considered in regard to employment: Do patients secure employment upon leaving a mental hospital? Do patients with employment readjust better than patients without work?

Since employment differs widely between the sexes, the male and female patients were analyzed separately. Another consideration was determining the patient's status before hospitalization. If a patient was working at the time of the onset of his mental disorder, he was considered

as "employed" regardless of how long this was prior to his admission. In cases where this could not be determined, the patient was considered unemployed, for it was thought unlikely that a patient's employment would be overlooked when the medical history was being secured. There were only six such instances. In the case of female patients another category had to be added - housewife.

The employment status after hospitalization was fixed at the time of the pre-discharge examination. As has been explained, if the patient makes a satisfactory adjustment during the year's trial period, the patient is discharged at the end of that year. The psychiatrist makes a decision on the basis of at least one of the following: his own examination of the patient; the report of the person in whose care the patient left the hospital; and the recommendation of the social worker who visited the patient at home. In many cases more than one of these were used, but fourteen patients were discharged without any of these observations. This is accounted for by the departmental regulations which do not permit a patient to continue under hospital supervision in the community without an examination at least once a year. If a patient was returned to the hospital before his year's trial was completed, the employment status during the interim was secured from the interval history.

DISTRIBUTION - Under these conditions, 72.2% of the males were found to have been employed before this admission (Table 57). After hospitalization only 39.4% were employed in private industry. When those working on WPA were added, the total was 47.6%. Twenty-four and six-tenths percent were definitely unemployed. The remainder were distributed as follows: eight and two-tenths percent were receiving public welfare aid; nine and eight-tenths percent had had only family care; and 11.5% were unknown. These figures are not too impressive. Even so, can the community expect a patient who was unable to work before hospitalization to be a laborer upon leaving the mental hospital?

After elimination of those who were unemployed before admission, the result was that one-fifth of the remaining patients were able to return to their former jobs or to secure similar work. One-quarter of those previously employed found other types of work during their year's trial period. Slightly over a tenth of them were on the WPA. Thus a total of 56.8% of the male patients previously employed were working a year after leaving the mental hospital. Those unemployed amounted to 15.9%. The other 27.3% were receiving welfare, had not left family care or were of unknown status.

These percentages do not agree with the results obtained in a previous study of 100 selected male patients discharged "on visit" from Worcester State Hospital between June, 1937, and December, 1940.[1] The age limits were 25 and 50 years. All of these patients were previously employed and all were discharged at the end of the year's trial visit. Eighty-one out of the hundred in that study were employed after hospitalization.[2] Of course, because of the differences in methods of selection, the results of the two studies are not comparable. Not only is there a disagreement in the incidence of employment, but also in the degree of readjustment, as will be seen later.

With the males who were unemployed before admission, it was found that 23.5% of them were able to secure a job, but none were working on the WPA (Table 57). Nearly half of them, or 47% to be exact, were unemployed also after hospitalization. All of which indicates that if a male patient was unemployed before being admitted to a mental hospital, he is more likely to remain so than if he had been previously employed.

A slightly higher portion of social service patients secured employment than of the non-service. The percent-

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[1] Murphy, _op. cit._, pp. 5-8.
[2] _Ibid._, pp. 27-28

ages were 50.1% and 45.2% (Table 57). This may be due to the fact that 76.7% of the male social service patients were employed before admission as compared with 67.7% of the non-service patients.

Fifty-two percent of the males employed before this admission were followed by social service. Of those unemployed at the onset of their mental disorder, only 41% received the service. Why this difference? Were the prognoses for patients who had not had previous employment so poor that social service would not be worth while?

Only 29.8% of the females had been employed before hospitalization; 18.5% had been unemployed and 51.7% were housewives (Table 58). Af first glance it may appear that there is a discrepancy between the proportion of housewives and the percentage of married females, which was stated previously as being 46% (Table 26). The reason for the difference is that the latter figure was based on the marital status on the date of admission, while the housewife status was determined at the time the mental disorder started. Following the onset of the illness two female patients had become separated from their husbands, another was divorced, and two more had become widows.

From the entire sample of female patients 13.9% secured employment after hospitalization, and 20.7% remained unemployed (Table 58). The largest group included

those who returned to resume their housewifely duties. Equal to that of the percent leaving the hospital in care of husbands (Table 52), this group composed 35.6% of the total. The statuses of the remaining female patients were as follows: nine and one-tenth percent receiving aid from public welfare; six and nine-tenths percent on family care only; four and six-tenths percent with relatives; nine and two-tenths percent unknown.

Of the female patients who had had work before their mental disorder 38.4% were reemployed after hospitalization, and 30.7% remained unemployed. Those who were neither employed nor housewives previous to this admission were six and three-tenths percent employed and 62.4% unemployed after leaving the hospital. As from the male statistics, the deduction is that female patients were more likely to get jobs if they were employed before admission to the mental hospital than if they were unemployed then. Yet the female patient's chances for getting employment were not as great as the male's regardless of previous experience.

Eleven and nine-tenths of the female social service patients were working during the year following their release from the hospital as compared with 17.8% of the non-service patients (Table 58). This small difference may rest on the fact that non-service category included slightly

Table 57: Employment After Hospitalization of Social Service and Non-Service Male Patients.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Employed Before This Admission						
Previous Work	5	16.7	4	12.9	9	14.7
Other Work	6	20.0	5	16.1	11	18.1
W P A	2	6.7	3	9.7	5	8.2
Unemployed	1	3.3	6	19.3	7	11.5
Welfare	3	10.0			3	4.9
Family Care	5	16.7			5	8.2
Unknown	1	3.3	3	9.7	4	6.6
Total	23	76.7	21	67.7	44	72.2
Unemployed Before This Admission						
Work	2	6.7	2	6.5	4	6.6
W P A						
Unemployed	3	10.0	5	16.1	8	13.1
Welfare	1	3.3	1	3.2	2	3.3
Family Care	1	3.3			1	1.6
Unknown			2	6.5	2	4.9
Total	7	23.3	10	32.2	17	27.9
Grand Total	30	100.0	31	100.0	61	100.1

Table 58: Employment After Hospitalization of Social Service and Non-Service Female Patients.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Employed Before This Admission						
Previous Work	5	8.5	5	17.8	10	11.5
Other Work						
W P A						
Unemployed	3	5.1	5	17.8	8	9.2
Welfare	2	3.4			2	2.3
Family Care	3	5.1			3	3.4
Unknown	2	3.4	1	3.6	3	3.4
Total	15	25.5	11	39.2	26	29.3
Unemployed Before This Admission						
Work	1	1.7			1	1.2
W P A						
Unemployed	5	8.5	5	17.8	10	11.5
Welfare	3	5.1			3	3.4
Family Care	1	1.7			1	1.2
Unknown	1	1.7			1	1.2
Total	11	18.7	5	17.8	16	18.5
Housewife Before This Admission						
Home	21	35.6	10	35.7	31	35.6
Work	1	1.7			1	1.2
Welfare	3	5.1			3	3.4
With Relatives	4	6.8			4	4.6
Family Care	2	3.4			2	2.3
Unknown	2	3.4	2	7.2	4	4.6
Total	33	56.0	12	42.9	45	51.7
Grand Total	59	100.2	28	99.9	87	100.0

more patients who had been working before this admission than did the social service classification. The percentages were 39.2% and 25.5% in order.

Housewives received the highest proportion of social service. Seventy-three percent of these patients were social work cases. According to status before admission the other patients received social service to the following degrees: 68.8% of the unemployed and 57.7% of the employed. Unlike the males, female patients who had no work experience were evidently considered in greater need of social service than those who had been working at the time their mental illness began. Why this difference in selection?

Summary: Seventy-percent of the males were employed before hospitalization. Nearly half secured work after returning to the community. Those previously employed had better than twice as good a chance of securing jobs as those unemployed prior to their mental breakdown. The incidence of social service was slightly higher among the males employed before this admission than those unemployed.

The status of the females prior to admission were employed, unemployed and housewife in a ratio of 3, 2, 5. After hospitalization this ration was approximately 1½, 2, 3½, with the remaining one-fifth divided among public wel-

fare, family care, relatives, and unknown. Females with jobs before admission had a higher percentage of employment during their visit period than did those who were unemployed previously. Regardless of status prior to the onset of mental illness, females had a smaller incidence of jobs than the males. Social service was given to the female groups, according to status prior to admission, in the following order: housewife, unemployed, and employed.

READJUSTMENT - Although the more detailed subdivisions of employment status were applicable in determining the distribution, these contained far too small frequencies to be validly used in computing rates of readjustment for each interval. Therefore, patients having any private employment or a WPA job were all combined into the employed status. The unemployed group remained unchanged, but the welfare, family care, and unknown patients were put into the "other" status.

Based upon status prior to admission, the results indicated that male patients who had been employed tended to readjust better than those who had been unemployed (Table 59). The former had 56.8% readjusted and the latter, 29.4%.

Of all the male patients who were employed after returning to the community 51.8% readjusted. Only one-third

of those who were unemployed after leaving the hospital remained in the community for three years. The total number of patients in the "other" groups showed a rate of readjustment that was higher than the two previous groups. It was 58.8%.

The female patients who were employed before being admitted to the mental hospital had a 61.5% rate of readjustment, the highest for the sex. Lowest were those without work before admission with a readjustment rate of 50%. Those who had been housewives were almost average in readjusting with a rate of 57.7%.

Three-fourths of the twelve females who secured work after hospitalization did not return to a mental hospital during the three year period covered by this study. Of the eighteen who were unemployed after leaving the hospital in 1938, only a third remained in the community. The "other" groups, unlike among the males, had an average rate of readjustment as 55.6% did not require rehospitalization.

Social service and non-service patients of both sexes were too few in each class to make definite conclusions from their rates of readjustments. Generally they showed the same trends as stated above.

Summary: In both sexes, patients who had employment before they were hospitalized for mental disorder had

higher rates of readjustment than those who had been unemployed. Female patients who had been housewives showed average rates of readjustment. Likewise patients who secured work after hospitalization readjusted better than those who did not. Social service and non-service showed the same general trends.

The importance of employment to the mental patient is widest. However, it is equally clear that just being employed does not guarantee the patient's complete readjustment to the community. Could the rate of readjustment have been raised through more thorough vocational counseling? Could this be achieved by closer co-operation between the hospital psychologist, occupational therapist and social worker?

Table 59: Number and Percent of Male Patients Readjusted in Each Employment Status by Service.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Employed Before This Admission						
Employed	8	61.5	6	50.0	14	56.0
Unemployed	0	.0	4	66.7	4	57.1
Other	5	55.5	2	66.7	7	58.3
Average	13	56.5	12	57.2	25	56.8
Unemployed Before This Admission						
Employed	0	.0	1	50.0	1	25.0
Unemployed	1	33.3	0	.0	1	12.5
Other	1	50.0	2	66.7	3	60.0
Average	2	28.6	3	30.0	5	29.4
Grand Average	15	50.0	15	48.5	30	49.2

Table 60: Number and Percent of Female Patients Readjusted in Each Employment Status by Service.

Status	Social Service		Non-Service		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Employed Before This Admission						
Employed	4	80.0	4	80.0	8	80.0
Unemployed	1	33.3	2	40.0	3	37.5
Other	5	71.4	0	.0	5	62.5
Average	10	66.7	6	54.5	16	61.5
Unemployed Before This Admission						
Employed	1	100.0			1	100.0
Unemployed	3	60.0	0	.0	3	30.0
Other	4	80.0			4	80.0
Average	8	72.5	0	.0	8	50.0
Housewife Before This Admission						
Home	11	52.4	9	90.0	20	64.5
Other	5	41.7	1	50.0	6	42.8
Average	16	48.5	10	83.3	26	57.7
Grand Average	34	57.7	16	57.2	50	57.5

XIII - CONCLUSION

To learn the characteristics of mental patients who are followed by psychiatric social workers as compared with those of patients who do not receive the service, and to discover what types of patients better readjust to the community were the foremost purposes of this thesis. Nine traits -- nativity, education, economic status, marital status, hospitalization, diagnosis, age, visit resource, and employment -- were analyzed with these aspects particularly. Each of these traits was applied to a sample of 148 unselected patients with mental disorder who returned to the community from Worcester State Hospital during the year 1938. Briefly the findings were:

DISTRIBUTION - First in comparing sex differences, it was found that the native born of native parentage were dominant among the female patients, while the native born of foreign parentage formed the largest nativity group among the males. Female patients had more secondary education than did males, three-fourths of whom did not go beyond grammar school. Seventy-five percent of both sexes

were of marginal economic status. The remainder, except for one male patient, were classified as financially dependent. Male patients were single in a majority of the cases, but most of the females were married. A little over half of the patients were hospitalized for less than a year, with female patients averaging longer hospital periods than the male. Schizophrenia was the most common mental disorder in both sexes. The diagnosis of alcoholic psychosis was next largest among the males. Affective psychoses were equally numerous among the opposite sex. Female patients were older than male patients at the time they returned to the community, the respective average ages being 43.4 and 40.1 years. As would be expected from the marriage statistics, the largest portion of female patients left the hospital in charge of their husbands. Males, however, were released in most cases to their parents. While 70% of the males were employed before the onset of their mental illness, the number employed after hospitalization dropped to only half of the total. Half of the female patients had been keeping house before their admission to the mental hospital. Thirty percent had been working and the remainder were unemployed. About 15% were employed upon return to the community. Male and female patients who had held jobs at the time of their mental breakdown had a better chance of securing work after leaving

the psychiatric hospital.

As for social service, about half of the male patients and two-thirds of the females were given assistance when leaving the hospital. An examination of the types of patients followed by social service within each sex revealed that more than half of foreign born males were social service cases. Of the females two-thirds or more of the foreign born, native born of native parents and native born of mixed parents were given the service. In analyzing the educational groups the evidence showed that the higher the school grade the smaller the proportion of patients receiving social service. A higher percentage of the dependent patients than of the marginal was selected by social service. In fact, all of the dependent female patients were assisted by the department. Comparatively speaking a greater portion of the single and formerly married patients than of the married were helped by the hospital social workers. Patients who remained in the hospital six to 12 months had the highest incidence of social service of the hospitalization groups. Male alcoholics had the highest proportion of social service of all the psychoses within that sex. Organic psychoses were most intensely followed among the female patients. Social service patients were older than the non-service patients. Those

patients who returned to the community in care of their mate received more social service than the other marital groups. From the employment statistics, it was learned that the percentage of social service was higher among male patients who had formerly been employed; while among the females the order of intensity was: housewife, unemployed, and employed.

READJUSTMENT - Readmission to a mental hospital within three years after discharge "on visit" was considered the single criterion of readjustment. On this basis, female patients readjusted more frequently than did the males. The rates were 57.5% and 49.2% respectively. Although social service patients had a higher rate than non-service of both sexes, the differences were almost minute.

When the characteristics were related to readjustment, the results regarding employment status were perhaps most significant to psychiatric social service. Patients who had been employed at the time of their mental breakdown had approximately twice as good a chance of securing work after hospitalization as patients who were previously unemployed. When either the statuses before or after hospitalization were used, the rates of readjustment were higher for the employed than the unemployed. Among the female patients, however, those patients who resumed their duties as house-

wives had the least number of readmissions.

Supplementing this evidence were the rates of readjustment according to economic status. Here both male and female patients of the marginal level showed higher rates of readjustment than did the financially dependent, especially in the former sex.

From these comparative degrees of readjustment, the importance of employment and economic security can be deduced. Furthermore such conclusions indicate a specific area within which psychiatric social workers can concentrate their efforts when assisting mental patients to readjust to the community. Case workers in mental hospitals would do well to consider the following questions: What therapeutic values does employment have to the patient? What effect does a mental patient, who is self-sufficient and employed after hospitalization, have upon community attitude? How can optimal employment placements of patients be made?

The readjustment rates of marital statuses and visit resource groups corroborated the above results somewhat. Patients who were single or returned to the community in care of their parents were rehospitalized most frequently.

The significances of the other traits are not as readily explained. The native born of foreign parents

showed the highest rates of readjustment, yet persons within this nativity group are generally believed to have much cultural conflict. Patients who completed the eighth grade and went no further in school had comparable rates among the educational groups. Length of hospitalization and readjustment did not show any correlation. The group of patients who remained in the mental hospital from six to 12 months unexplicably had the highest percent of readjustments. Then, too, the elderly patients unexpectedly readjusted better than did those middle aged or younger. And lastly, the differences in readjustment of the psychoses were surprisingly small.

CRITIQUE - One of the main criticisms of this study may rightly be an attack upon the smallness, the inadequacy of the sampling within a number of the class intervals. Although these exist, the conclusions that were made from them were always guarded. Furthermore, the actual statistics were included along with the text so that percentage figures would not be taken for more than their true worth.

As the results stand at the conclusion of this work, the interrelationships of the various traits analyzed are not indicated. No correlations were computed. Furthermore, critical ratios were neither obtained, so that the degree to which the variations in distribution and read-

Table 61: Relation Between Low Readjustment Rates and Incidence of Social Service Among Male Patients.

Category	Interval with Low Readjustment Rate	Incidence of Social Service
Nativity	Native Born of Foreign Parents	Low
Education	Above Eighth Grade	Low
Economic Status	Dependent	High
Marital Status	Single	Low
Hospitalization	Over 24 Months	Low
Diagnosis	(All Average)	
Age	Under 50 Years	Low
Visit Resource	Parent	Low
Employment	Unemployed	Low

justment may be due to chance, because of the limited sampling, is not known. All these weaknesses are recognized, but time did not permit a more thorough analysis.

Such further study could well be undertaken in the future. In fact this thesis raises many questions which are vital to the field of psychiatric social work, questions which will need clarification if case work assistance is to be increasingly helpful to mental hospital patients endeavoring to readjust to community life.

RECOMMENDATIONS - In the outline of the purposes it was declared that an attempt would be made to ascertain what steps might have been taken to insure a more satisfactory readjustment of the patient to the community. For this reason, attention is focused on the patients who appeared to need most help as shown by the rates of readmissions. All the groups with rates significantly lower than the average for each sex were selected and compared with the incidence of social service received by them.

Thus the poorly readjusted male (Table 61) was found to have been native born of foreign parents, and dependent economically. He had a better than grammar school education but he was single. He was less than 50 years of age and had been hospitalized for two years or more. When leaving the hospital, he was supervised by his parents.

As he had no employment prior to his hospitalization, the chance of his getting work after returning home was fairly slim. As for his diagnosis this did not seem to be important in his readjustment to the community.

All these traits appear to support each other. For instance, this male patient who readjusted poorly was dependent because he was unemployed. Also, being single, he had to return to his own parents after hospitalization. In placing these factors together like this, however, a word of caution must be included. The degree to which these criteria are interrelated was not determined in the study. Still each was individually shown to be a factor related to poor readjustment. Therefore, the portion of patients receiving social service in each of these groups was separately compared with the averages for the sexes.

Seven of the eight groups with low rates of readjustment received comparatively little assistance from the social service department. Yet these were the patients who returned to the hospital most frequently. Would it not seem that the problems of these patients in the community require the study and increased attention of psychiatric social workers?

In the case of the male patients who were classified as economically dependent, social service was already spend-

Table 62: Relation Between Low Readjustment Rates and Incidence of Social Service Among Female Patients.

Category	Interval with Low Readjustment Rate	Incidence of Social Service
Nativity	Native Born of Mixed Parents	High
	Native Born of Native Parents	Average
Education	Above Eighth Grade	Low
Economic Status	Dependent	High
Marital Status	Single	Low
Hospitalization	Over 24 Months	Average
Diagnosis	Organic	High
Age	Under 50 Years	Low
Visit Resource	Parent	Low
Employment	Unemployed	Average

ing considerable time. How much lower the rate of readjustment would have been if this assistance had been less intense cannot be even surmised. But a question that should be thoroughly considered is: are the patients within this group incapable of making any higher degree of readjustment or are the social work techniques not meeting the patients' needs?

Turning to the female patient (Table 62), the characteristics were somewhat different. Here both the native born of either native parentage or of mixed parentage showed equally poor readjustment. In education, the patient tried to go beyond grammar school but did not complete high school. Like the male, she too was single, dependent and unemployed. She was less than fifty years old and had been in the hospital over 24 months. Her diagnosis was organic psychosis. On leaving the hospital she returned home in care of her parents.

Unlike the male patients with low readjustment rates, the female patients with an equally high frequency of rehospitalization received more assistance from the social service department. Three groups received more than the average percentage of social service. In three others the incidence was equal to the average for the sex. The remaining four contained few social service cases. Why did the patients show poor readjustment even when comparatively

high percentages of them were either given intensive social service, placed in family care or helped in arranging visit resources?

It would be interesting to know on what grounds the non-service patients were not assisted by the hospital social workers. Was it because their prognoses were considered good? If this were known, the low readjustment rates under social service would be understandable. Perhaps it would prove valuable to insert in the records of those who are not followed by social service the reasons for not extending the service to the patient and how well it is believed he will be able to readjust to the community. Also, why couldn't the prognoses of social service cases be included as well as a record of the case worker's objectives?

Of course, it is recognized that the facts presented are for the year 1938 and not 1942. The policies and organization of the social service department within the hospital have changed considerably in the interim. Nevertheless these figures may serve as a standard with which current work may be compared in order to learn what progress has been made in helping patients readjust to the community.

APPENDIX A

(Schedule used in securing information from individual patients' records.)

Name: Diagnosis:

Age on Release: Nationality: Race:

Birthplace of Patient: Of Father:
Of Mother:

Education: I.Q.: Occupation:

No. of Previous Admissions: Length in Months:

Length of This Admission: Total Hospitalization:

Date Discharged on Visit: Discharged:
Continued:
Disceased:

No. of Times Seen by Doctor: Discharge Exam: Yes No

Visit Resource: ORRA:

Occupation: Duration of Visit:

Date of Rehospitalization:

No. of Social Service Contacts: Duration:

Pre-discharge Visit by Social Worker: Yes No

Economic Status: Marital Status:

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